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ABSTRACT

Home visiting is the strategy used by the Community Mothers Programme to enhance parenting skills of first-time mothers from economically disadvantaged areas in Dublin, Ireland. The home visitors are all women from the community who volunteer to visit parents in their homes once a month for 1 hour over a 12-month period. In a 1989 evaluation, 232 first-time mothers were randomly selected to be in either a group receiving the program or in a control group that did not. The study, conducted when their infants were 1-year-old, showed favorable outcomes for the program families compared with control families in areas such as maternal self-esteem, maternal and child nutrition, developmental stimulation, maternal morale and well-being, and immunization. Seven years later, when the children were age 8, a follow-up study traced one-third of the families from the 1990 study. A major finding was the persistence of superior parenting skills among the program families. Children whose mothers had been in the program were more likely to read books, to visit the library regularly, and to have better nutritional intake than children in the control group. Mothers had higher levels of self-esteem. They were also more likely to oppose smacking their child, to have developed strategies to help them and their children deal with conflict, to enjoy participating in their children's games, to have better nutritional intake, and to express positive feelings about motherhood. (The follow-up study questionnaire is appended. Contains 11 references.) (KB)

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Early Childhood Development: Practice and Reflections

Following Footsteps

Still going strong

A tracer study of the Community Mothers Programme, Dublin, Ireland

Brenda Molloy

PS 033314

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Foundation

About the Bernard van Leer Foundation

The mission of the Bernard van Leer Foundation is to enhance opportunities for children 0-8 years, growing up in circumstances of social and economic disadvantage.

The objective is to develop children's innate potential to the greatest extent possible. We concentrate on children 0-8 years because research findings have demonstrated that interventions in the early years of childhood are most effective in yielding lasting benefits to children and society.

We accomplish our mission through two interconnected strategies:

- a grant-making programme in 40 countries aimed at developing contextually appropriate approaches to early childhood care and development; and

- the sharing of knowledge and know-how in the domain of early childhood development that primarily draws on the experiences generated by the projects that the Foundation supports, with the aim of informing and influencing policy and practice.

The Bernard van Leer Foundation was established in 1949. Its income is derived from the bequest of Bernard van Leer, a Dutch industrialist and philanthropist, who lived from 1883 to 1958.
Bernard van Leer was the founder of the Royal Packaging Industries Van Leer.

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Early Childhood Development: Practice and Reflections

Following Footsteps

Still going strong

A tracer study of the Community Mothers Programme, Dublin, Ireland

Bernard Van Leer

April 2002

reports of studies tracing the 'footsteps' of former participants in early childhood programmes

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About Following Footsteps

Following Footsteps are reports of efforts to trace former participants of early childhood projects and programmes. They are studies that follow the progress of the children, their families, the workers, the communities or the organisations five or more years down the line to find out how they are faring. Some of the programmes were originally supported by the Bernard van Leer Foundation; others were not. Some of the studies were commissioned by the Bernard van Leer Foundation, while others were not. Each of the programmes studied is unique, and the methods used for tracing, gathering data and analysing are many and varied. As a whole, the studies will contribute to our understanding of the effects, and effectiveness, of early childhood programmes.

About the series

Following Footsteps is a sub-series of *Early Childhood Development: Practice and Reflections*. The series as a whole addresses issues of importance to practitioners, policy makers and academics concerned with meeting the educational and developmental needs of disadvantaged children in developing and industrial societies. Contributions to this series are welcomed. They can be drawn from theory or practice, and can be a maximum of 30,000 words. Information about contributing to the series can be obtained from Diane Lemieux, Series Editor, Department of Programme Documentation and Communication at the address given on the back cover.

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About the author

Brenda Molloy is the Director of the Community Mothers Programme. She is employed by the Eastern Regional Health Authority in Dublin, Republic of Ireland. She trained as a Health Visitor in England. She has specialised in parent support and peer-led interventions since 1983. She obtained her BA from the Open University, Milton Keynes, England and her M.Sc. (Sociology) at Trinity College, Dublin. She has advised on the setting up of peer-led interventions in Europe and Australia. She is married to Sean and the mother of three children, Luke, Mary and Grainne.

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Praise and encouragement can help a child to develop confidence and self-esteem.

This Cartoon shows how some parents help their children develop by giving them praise and encouragement.

Instead of telling her child that he's 'bold' when he touches things, Marion **encourages his curiosity** by allowing him to explore.

Instead of correcting every mistake that her child makes, Bernie accepts mistakes as part of learning and **encourages her child to try again.**

Instead of constantly criticising her child, Sheila gives her **plenty of praise**.

Along with all their praise and encouragement, Maura and Jim **regularly tell** their child that they love her.

Praise from Mammy and Daddy is the most important praise of all.

Foreword

Many early childhood programmes use home visiting as a strategy; in the Community Mothers Programme (CMP), it is **the** strategy. This is a programme that has evolved since 1980, first using professionally trained nurses as visitors to families with newborn babies, and then training experienced mothers from the community to visit families who have just had their first babies. It is also a programme that has continually evaluated its methods and adapted them in accordance with the findings, as well as to changing circumstances in society.

The Dublin of 2002 is a very different place from the Dublin of 1980. An economic boom – known locally as the 'Celtic Tiger' – has brought highly skilled employment and increased prosperity to many citizens. But, as this report clearly explains, there are individuals and families who have been left behind, who have no educational qualifications, who live on welfare in unsatisfactory housing, and whose children have little chance of reaching their full potential. And this is where the Programme comes in.

The CMP attempts to bridge the gap between 'the public world of the bureaucrat and the private world of mothers'. It is an integral part of the Eastern Regional Health Authority (formerly the Eastern Health Board) and it is implemented by women from the community. Using a clear and flexible set of strategies, Community Mothers are empowered and trained to visit parents (usually mothers) of firstborns to offer encouragement and support. At the time these studies were undertaken, the objective was to visit once a month for just one hour over a twelve-month period.

Can just 12 contact hours over a year make any difference to the child and the mother? Remarkably, this report shows that it can. In 1989, 232 first-time mothers were randomly selected to be in either a group receiving the CMP or a control group without the CMP, and they were all followed up a year later when their babies were one year old. The results were encouraging and showed favourable outcomes for the Programme families – when compared with the control families – in areas such as maternal self-esteem, maternal and child nutrition, developmental stimulation, maternal morale and well-being, and immunisation. These are, in themselves, good outcomes at the end of a one-year programme.

Seven years later, when the children were aged eight, a follow-up study attempted to trace the families from the 1990 study and was able to find one-third of them. This report includes a description of that research and the findings. A major finding was the persistence of superior parenting skills among the Programme families. Children whose

cartoon: Artwork and layout: Gordon Harper, © 2000 Community Mothers Programme

mothers had been in the CMP were more likely to read books, to visit the library regularly, to have better nutritional intake. Mothers had higher levels of self-esteem. They were also more likely to oppose smacking, to have developed strategies to help them and their children deal with conflict, to enjoy participating in their children's games, to have better nutritional intake, and to express positive feelings about motherhood.

Not all of the differences between the Programme and the Control families are statistically significant. Nevertheless, these results are more than remarkable – they are quite astonishing when we recall that they are the result of a maximum of 12 contact hours in the first year of the child's life. However, the Programme recognises that there is more work that needs to be done in the area of nutrition and, as a direct result of continuing and regular evaluation, the CMP has been extended to cover the first 24 months of a child's life with the aim of achieving a permanent improvement in maternal and child nutrition.

The origins of the CMP are in a pilot child development programme, begun in 1980, that included disadvantaged families in six health authorities – the one in Dublin and five others in England and Wales. In 1988, when the pilot had developed into the CMP, I met senior officers of the Eastern Health Board (as it was then called) and asked why they had agreed to participate in the pilot project. They referred to a project in Dublin from 1969 to 1974 that, with support from the Bernard van Leer Foundation, had developed a preschool project for children aged three to five years in the Rutland Street area. While the initial results had been good, they explained, the gains had generally not been sustained in later years, which led them to two conclusions. One was that parents needed to be involved in such programmes, and the second was that intervention should start earlier, preferably from birth. Thus, when the opportunity arose to be part of a pilot project that started at birth and involved parents, they decided to take it.

In the decades since that first project, our thinking and knowledge about early childhood programmes has developed considerably. And in Ireland, because of that first experience, there is a programme that operates at the community level, that begins at or even before birth, that empowers the women who implement the programme as well as the families that are visited, and that is helping some two thousand children a year to reach towards their full potential.

The tracer studies

The early childhood interventions supported by the Foundation are action projects that are implemented by locally based partners in 'the field'. Their objectives are concerned with developing and improving the lives of children and their families and communities

in the here and now, based on the hypothesis that this will lay the foundations for improved opportunities in the future. These projects have not been conceived or implemented as research studies in which children/families have been randomly assigned to 'treatment' or 'control' groups, and they have not usually been subjected to tests or other research instruments.

In that respect, this study from Ireland is unusual in that families were randomly assigned to be part of the CMP or to be controls. An informed decision was made for a randomised controlled trial but, like other interventions, the CMP was designed for action and not primarily for research.

Evidence exists on the longer-term effects of early childhood interventions, much of it coming from longitudinal studies that have been implemented as research projects in industrialised countries. The outcomes are mixed, although usually fairly positive. Other evidence, mostly anecdotal, is available from early childhood projects such as those supported by the Foundation, and again, this is mostly positive.

After more than 30 years of support for field projects, the Foundation decided in 1998 to commission a number of studies that would trace former participants of projects to find out how they were faring a minimum of five years after they had left the programme. Although evaluation has been a major element in early childhood programmes supported by the Foundation, we have never, until now, gone back to find out how people are doing a number of years later.

Other similar studies are taking place, or have been completed, in countries as widely spread as Jamaica and Kenya, Israel and India, the USA, Botswana, Colombia, and Trinidad. Each of the programmes studied is different in its target group, in its context, and in its strategies. This means that the methods used to trace former participants and discover their current status are almost as varied as the original programmes. In the studies that we have commissioned, we are emphasising an anthropological and qualitative approach that uses small samples of former participants and, where possible, matches them with individuals/families that share similar characteristics for the purpose of comparison.

The seven-year follow-up study which is described in this report was carried out by the Health Information Unit of the Eastern Regional Health Authority in collaboration with the CMP and the Department of Public Health Medicine and Epidemiology at University College Dublin, and we are grateful to the Eastern Regional Health Authority for allowing us to publish this report.

Our intention is to share the results of the individual studies with as wide an audience as possible, as well as to undertake an analysis of a group of the studies to see what lessons can be learned in terms of both outcomes and methods.

We anticipate that each study report will be a source of learning and reflection in its own context and country as well as for a wider public. As a whole, we hope that these exercises in following footsteps will contribute to a better understanding of the effects, and effectiveness, of early childhood programmes.

Ruth N Cohen
Bernard van Leer Foundation

photo Programme children, photo courtesy Community Mothers Programme

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Acknowledgements

Many people have been involved in bringing the Community Mothers Programme into the new millennium. I would like to express my thanks to all those who have been involved with the Programme over the years whether or not their names appear in this acknowledgement. I would like to thank especially the Programme families, the Community Mothers, the Family Development Nurses, the former Eastern Health Board for their vision in starting the Programme, the Eastern Regional Health Authority and the three Area Health Boards who continue to support the Programme, the Bernard van Leer Foundation for its support in funding the Programme during the early years, the Health Information Unit, Eastern Regional Health Authority for their support with the evaluation throughout the life of the Programme, and the Directors of Public Health Nursing and the Public Health Nurses.

In particular, I would like to acknowledge the invaluable help and support I received from the late Dr Zachary Johnson, also, Dr Patricia Fitzpatrick and Elaine Scallon who assisted with the evaluations. A very special thanks goes to Gordon Harper and Phyllis Rodgers for their unfailing support and help with the development of the Programme materials and illustrated sheets. Thanks are also due to Eilonnuala Kinsella for typing this report.

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Executive summary

The Community Mothers Programme (CMP) is a support programme for first-time – and some second-time – parents of children aged 0 to 24 months who live in mainly disadvantaged areas. This includes, lone parents, teenage parents, Travellers (see Chapter three), asylum-seekers and refugees. Following pilot phases, the CMP was formally launched in the former Eastern Health Board, Republic of Ireland, in 1988. Today it is delivered to nearly two thousand parents each year.

The Programme aims to support and aid the development of parenting skills, thereby enhancing parents' confidence and self-esteem. It is delivered by non-professional volunteer mothers known as Community Mothers, who are trained and supported by Family Development Nurses. The Community Mothers visit parents in their own homes once a month and use a specially designed child development programme, which focuses on health care, nutritional improvement and overall development. The Programme model is one of parent enablement and empowerment. This report describes the context of the CMP, its evolution from a pilot project in 1980, and the evaluations and research that have been carried out on it.

In 1990, the programme was evaluated by a randomised controlled trial when programme children were one year old (Johnson, Howell and Molloy, 1993) and was found to have significant beneficial effects for both mothers and children. Children in the intervention group scored better in terms of immunisation, cognitive stimulation and nutrition, and their mothers scored better in terms of nutrition and self-esteem than those in the control group. At that time the programme was aimed only at first-time parents during the first 12 months of the child's life; parents received a maximum of 12 visits, usually one per month, each lasting approximately one hour.

In 1997-1998 a seven-year follow-up study (Johnson et al., 2000) was done to find out whether the benefits of the Programme had been sustained over the intervening period, by which time the children were eight years of age.

Approximately one-third of the mothers who had been in the original intervention and control groups were located and asked for details on the child's health, the diet of both mother and child, the development of the child and the mother's parenting skills and feelings of self-esteem.

In a nutshell, the findings were very positive: intervention mothers were more likely to check their child's homework every night and to disagree with the statement 'Children should be smacked for persistently bad behaviour', mothers in the intervention group demonstrated higher self-esteem and greater enthusiasm for motherhood, intervention children were less likely to have an accident (although more likely to have been hospitalised for an illness), and subsequent children of the intervention mothers were more likely to have completed their primary immunisation programme.

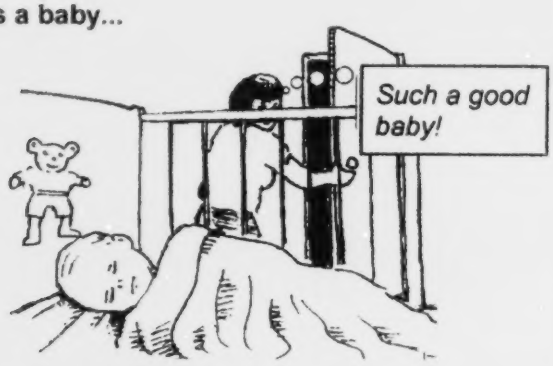
The conclusion is that the CMP has a beneficial impact on parenting skills and maternal self-esteem that is sustained over time and which is carried through to subsequent children. In order to enhance these effects even further, and as a direct result of continuing and regular evaluation, the Programme has been extended to the first 24 months of the child's life.

cartoons Artwork and layout: Gordon Harper, © 2000 Community Mothers Programme

Some children are so quiet that it is easy to overlook their needs.

Tracey is pleased that her child is so quiet...

As a baby...



As a one year old...

As a two year old...

Patricia makes sure that her 'quiet' child is well stimulated...

As a baby...

As a one year old...

As a two year old...

Children need a great deal of structured stimulation to bring out their talents.

Setting the scene

Socio-economic conditions

Much has changed in Ireland in recent years. In the 1980s the scene was one of recession and spiralling public debt; today the economy has been transformed, having seen spectacular growth since the mid-1990s with a high level of foreign investment. There is growing prosperity, and as more people move to Ireland to live, the society is becoming increasingly diverse and multiracial. Economic growth has brought major benefits to the country, with fewer people living in poverty and low unemployment levels. The challenge now is to ensure that the benefits are shared equally so that there are sustainable improvements in the economic well-being of all.

One negative side effect of a high economic growth rate is increased levels of inequality in income and a wider gap in the standard of living between the rich and the poor. Despite the recent high levels of economic growth, there is a well-documented increase in the number of people living in relative poverty. These are the people for whom the 'Celtic Tiger' – as our economic boom is known – means nothing. They battle with the same kind of poverty that they always had. While expenditure has increased in areas like educational disadvantage, social welfare, health, childcare and housing, much more needs to be done. Homelessness is the ultimate form of social exclusion. In Ireland, there were more than 5,000 people assessed as homeless in 1999, compared with 2,000 in 1996.

Despite comprising almost one-third of the population, children remain unrecognised in many areas of policy that nevertheless have a huge impact on their lives. About 25 percent of children live below the poverty line and many experience social problems that include poverty, educational disadvantage, abuse, neglect and discrimination. Research has shown that the combined pressures of unemployment, poverty, substance abuse, lone parenthood and the lack of naturally occurring support networks, such as the extended family living close by, can make it difficult for parents to promote the kind of nurturing care that their children need. The change in communities has also had an impact on children. For example, in the 1980s the housing estates around Dublin were largely composed of same-age families where the children played, grew up, and went to school together. Now children are more isolated. If it were not for playgroups, some children would be dependent on adults and television for their social interaction. Many housing estates today contain a mix of people of different circumstances, backgrounds and attitudes so that many families are becoming increasingly isolated.

More mothers are also working outside the home. The pros and cons of mothers

photo: The programme in action, photo courtesy Community Mothers Programme

working are often debated, but for the vast majority of people, giving up paid employment is not an easy option, especially as housing costs are high. Those who have employment often find that they are being asked to sacrifice a home life in order to succeed at work. There are children who leave home early in the morning to go to child daycare and return late in the evening, which, in winter, can mean not seeing the neighbours for months on end and having less opportunity to make friends.

Supporting parents

The pressures of modern society mean that all parents, and particularly those who live in areas of social stress and disadvantage, need support if they are to promote the health and development of their children, their families and the next generation as a whole. It is now accepted that there is a link between childhood experiences and adult outcomes. Accordingly, failure to provide good quality support in the early years of childrearing means that a much higher level of resources may need to be invested by the health, social and education services in later years in order to address and overcome the many problems that have arisen as a result. For this reason, parent support services are currently on the increase in Ireland.

If the aim of parent support is to enable parents to maximise their role and so enable their children to reach their full potential, then the quality of the parent-child interaction and the parents' self-esteem and confidence is of prime importance. It is accepted that parents may need more support at critical times, such as the birth of a first child. It is also recognised that changing family and employment patterns, poverty, the problem of violence, the greater accessibility of drugs, and increasing media and professional pressures to 'do the job well' all put extra strain on parents.

In Ireland, there is a range of support services available to parents. These include visits from Public Health Nurses who visit all parents in their own homes during the first weeks of the child's life and make further routine visits for up to three years. There is also a range of targeted family support services provided by the Health Boards and by voluntary organisations, including family support workers, home visiting programmes, family resource centres and initiatives with teenage parents. In addition, there is a range of group-based parenting courses held at various venues such as in schools and local parishes. As well as providing high quality childhood services, it is recognised that parent support should also include close links between parent and school, flexible working conditions, and adequate housing, income and employment.

However, there is still a crisis-driven approach to providing services rather than an approach that favours prevention and early intervention.

Giving the right type of support is very important – different approaches suit different parents, depending on their situation. Increasingly, new mechanisms and strategies are being examined. While professionals have an important role in this, they often do not have the ability to provide all the elements of effective parent support. In addition to professional services, families need support networks to promote a sense of belonging and connection to the community. These networks form part of the social capital of individuals and families and, like financial, physical and human resources, they contribute to health and well-being. Programmes like the Community Mothers Programme can provide a source of support to the family and help in building its social network.

In Ireland, there is now a greater awareness of the government's role in supporting parents. Until recently there was little interference in the family unit unless there was extreme neglect or abuse. The state mainly provided financial support for families through the social welfare system, the provision of emotional support being the domain of family, friends and relatives. However, since the mid-1990s there has been a move towards prevention and promotion, and a number of policy documents have been published that have called for a greater focus on prevention and early intervention in order to reduce the need for crisis intervention (Commission on the Family, 1998; Department of Health and Children, 2000).

The Eastern Regional Health Authority

The Eastern Regional Health Authority was established in March 2000. It is the statutory body for health and personal social services for the 1.3 million people who live in the counties of Dublin, Kildare and Wicklow. The Authority is not directly involved in the delivery of services; it provides funding and is also responsible for monitoring services to ensure that they are of good quality, are delivered efficiently and effectively and are good value for money. Service delivery is the responsibility of the three Area Health Boards that replaced the former Eastern Health Board, the Voluntary Hospitals and a number of other voluntary agencies in the region. In addition to the delivery of statutory services, the Health Boards also plan and coordinate all services within their areas. The new structures were introduced to cope with the increased population. In the 1970s the former Eastern Health Board delivered services to 900,000 people, but the population of the same area is now 1.3 million.

Community Involvement

There is an Irish tradition of caring that has been carried out mainly by churches, charities and other groups with no religious affiliation. Historically, there is also plenty of evidence of neighbourliness in Ireland. In the past, the only system of social services available was often the natural caring networks of family, friends and neighbours. These natural caring networks have been put under strain in recent years.

The 'Celtic Tiger' has reduced the pool of people who are available to care and get involved in community activities. Part-time work is available and many married women are being attracted back to work. In 1999, 43 percent of the parents in the CMP were working outside the home, compared to 29 percent in 1990. Also in 1999, 45 percent of the Community Mothers were in paid employment in addition to their work as a volunteer. This is in contrast to a figure of only 20 percent in 1990.

Our value systems have also changed in recent years. Volunteers are becoming harder to find. Earning money to provide for and protect oneself and one's family is time-consuming – people have less spare time. Housing estates are often empty during the day, with children in daycare or crèche, while the parents commute to and from work. This has reduced community involvement and connectedness and has contributed to increased social isolation.

Interweaving formal and informal networks

Since its inception, the CMP has essentially been based in the community as well as being dependent on a formal organisation and, to a large extent, firmly part of the formal system. Most of the problems in the early years revolved around keeping a balance between these formal and informal worlds. The CMP can be seen as an attempt to bring together the public world of the bureaucrat with the private world of mothers, which can, and has, lead to tensions.

It might appear on the surface that a simple partnership between the informal system and the formal system could occur with each side maximising its own strengths. But in practice, what appear to be complementary functions can give rise to contradictory perspectives. Organisational and professional dilemmas can cause tensions and strain that make collaborative efforts difficult.

One difficulty from the point of view of the informal system has been shown in the use of indigenous paraprofessionals as bridges to poor communities. These informal helpers can take on professional roles and come to identify more with the interests of formally organised service agencies than with the community, with the result that the attempt to foster participation is lost and can result in the 'professionalisation' of the informal care sector (Molloy 1992).

The CMP is intended to stimulate and build on the helping networks that exist in the community, but it is important that the Community Mothers are not turned into workers and that neighbours are not turned into clients. There is also the risk of 'colonisation' of the informal system, where the informal social networks of the neighbourhood are seized by statutory and voluntary agencies for their own ends, creating dependency on the agencies. The agencies' own preferred hierarchies of control may then be imposed on local social systems.

Overall, the success of the CMP has shown that the two need not be antithetical, but great care is needed to interweave the two systems in a way that avoids incorporation of the informal by the formal. The aim is to enable the statutory services to interweave their help so as to use and strengthen the help already given, to overcome existing limitations and to facilitate a process of empowerment in the community. It is not a question of plugging the gaps, but of working with society to close the gaps.

Involving volunteers in relationships with parents

Research revealed that in relationships with families, volunteers have advantages over professionals (Molloy, 1992). For example, it has been shown that a mother's relationship with a volunteer can be warm and intimate for a number of reasons.

A disadvantage for professionals is the perceived power, or authority, with which they enter homes, and this perception may have a negative effect, particularly in families who may feel powerless to deal with their problems. They may view the professional visit as an 'affirmation of their affliction'. In some cases, visits may even be seen as threatening and may thus be counterproductive. The 'power' relationship may be related to specific knowledge. In the case of social workers, for instance, it may be related to their power to remove children from families. Where the approach to families is from a position of power and strength, the result is that the interaction fails to capacitate parents and to allow them to achieve things for themselves.

Professional and peer resources are used in different ways. The latter usually provides a pool of potential relationships from which friends can be chosen. In contrast, the professionals usually remain in an asymmetrical relationship as they are not peers and, as a result, rarely become new members of the client's network of friends. In most cases, professionals cannot enter into a deep personal commitment with any one family because they have to remain objective in order to do their job. In addition, professionals often make brief and seemingly random visits and personnel may be frequently changed, so the purpose of the visits may not be fully appreciated by the families in question.

Volunteers, on the other hand, have the advantages of being in a position to spend more time with the people they visit and the atmosphere tends to be more relaxed and informal. Their time can be adjusted more easily to suit specific needs.

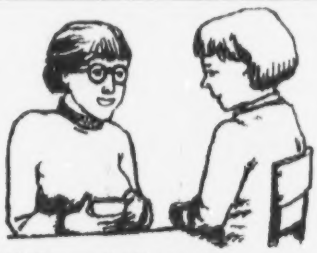
In summary, the professional and volunteer relationship may complement one another but they are totally different. The professional is 'problem oriented' while the volunteer is 'person focused' in essence. Volunteers can therefore play a supportive role, whereas the professional tends to provide a service.

photo: Programme child, photo courtesy Community Mothers Programme

From Mother To Mother.

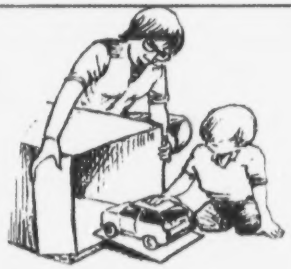
"I breast-fed my baby and found that it was very good for both of us."

"I listen to what my baby is trying to say and this helps me know how to respond to him."



"I found that it's important to take time to keep in touch with my friends."

"I prepare my own baby food. It is cheaper than tins or jars and a lot more enjoyable."



"I've found some good ways of saving money. Sometimes, instead of going out and buying things, I use card- board boxes and my child gets endless fun playing with them."

"I don't struggle with impossible routines. I relax and enjoy my baby. My baby is learning more because I'm spending time with him when he's awake."

"I make myself a sandwich when I get up in the morning. This means I can have something ready to eat when I need it."

The Community Mothers Programme: an effective intervention

The Community Mothers Programme is a support programme for parents in which local women, known as Community Mothers, make structured visits once a month to parents in their own homes, providing empathy and information in a non-directive way to foster parenting skills and parental self-esteem. The Community Mothers are all experienced mothers who work on a voluntary basis and typically spend upwards of 13 hours each month on their visits to between five and 15 families.

From the point of view of the Community Mothers, the Programme helps to increase their feelings of self-worth as they see the parents developing an understanding of child development, and they find themselves gaining status in their own community. At the same time, the parents are empowered to believe in their own capabilities and skills for parenting without becoming dependent on professionals. The Family Development Nurses who facilitate the Programme become 'de-roled' in the process and for them, it is a move away from 'nurse knows best' to working in partnership with the community.

The Family Development Nurses are all Public Health Nurses who have received special training for this role. They train the Community Mothers and give them support to enable them to visit all first-time parents and, more recently, some second-time parents in their area. Parents are given information on child development, health and nutrition. The main focus of the Community Mother's visits is to encourage the new parents, both mothers and fathers, to set themselves targets for achievement during the month before the next visit, and to facilitate the development of the child, both physically and mentally. This is done by drawing out the parents' own potential rather than by giving advice and direction. The parents are acknowledged as the experts with their own child and support is given to them to help them achieve their own goals for their child's development.

Background to the programme

The Programme targets disadvantaged areas with high birth rates. The criteria for selection include housing type, social class, education and unemployment, derived from the population census and other sources. It is a community health initiative that has gone through three distinct stages. In the first of these stages, it was part of a pilot home visiting project; in the second stage, it was developed in four different parts of Dublin; and in the third stage, it became what is now known as the Community Mothers Programme.

cartoon: Artwork and layout: Gordon Harper, © 2000 Community Mothers Programme

Throughout all these stages, the strategies were continually being adapted and developed, as they continue to be in the current programme.

First stage: a pilot project

The CMP has its origins in the Child Development Project that is based in the United Kingdom. In 1980 the Eastern Health Board (EHB – now the Eastern Regional Health Authority) was one of six health authorities (the other five being in England and Wales) that agreed to take part in a large-scale pilot project. In this project, over 1,000 parents, all living in disadvantaged areas, were visited by specially trained personnel. In Ireland these personnel were Public Health Nurses (PHNs) and in England and Wales they were Health Visitors. The funding for this pilot project came from the Bernard van Leer Foundation.

In Dublin, nine PHNs were given training and subsequently made monthly home visits, over a period of two years, to first-time parents as well as parents with two or more children. These parents were selected from disadvantaged housing estates throughout the EHB area. Results from the project evaluation showed that the visiting programme was effective for parents and children and should be continued on a more permanent basis.

Second stage: Early Childhood Development Programme

The PHNs who had implemented the pilot project had many other commitments to existing prevention and treatment activities in the community at large and were not able to continue implementing the visiting programme. It was therefore decided to pilot a community-based programme using experienced mothers as non-professionals to visit and support other mothers. This was called the Early Childhood Development Programme and the visiting mothers were known as Child Development Aides.

It was decided at this stage to concentrate on first-time mothers and fathers, since it was felt that any developments with this group of parents would influence their childrearing with all their subsequent children. The parents were to be visited for the first year of their child's life. Funding for this phase of development, which lasted from 1983 to 1985, again came from the Bernard van Leer Foundation, but this time it was a direct agreement with the EHB and not via the UK-based Child Development Project. None of the nine PHNs who had been involved in the pilot Child Development Programme wished to be involved in this phase; instead, four coordinators known as Family Development Nurses were appointed to develop and implement the Programme in four different areas of Dublin.

During this period, the Programme was developed successfully by the author in Coolock, a suburb of Dublin, and it was from this experience that the CMP was to evolve. The name 'Community Mother'

was coined by the author and the late Eithne O'Rourke, a volunteer mother in Coolock, who was very committed to the Programme.

In general, the development and implementation of the Programme was very difficult because the Nurse Managers, the local Public Health Nurses and, indeed, Health Board Management were very anxious about 'ordinary' mothers getting involved in primary relationships with families – nothing like this had ever been done before and there were no precedents to follow. It was a case of trial and error, learning by doing, and adapting as necessary.

Third stage: the Community Mothers Programme

In 1988, the EHB again approached the Bernard van Leer Foundation to fund this phase of the Programme in its early stages. The author, who had since left the Programme, was appointed to expand and develop the 'Coolock model'. This new programme was now named the Community Mothers Programme. The author set about developing and implementing the Coolock model throughout the EHB area, undertaking a formal evaluation of the effectiveness of the CMP at the same time, with the late Dr Zachary Johnson and the Department of Community Health, Trinity College, Dublin.

Today the CMP is operating throughout the counties of Dublin, Wicklow and Kildare. There are 130 Community Mothers who visit approximately 1,200 first-time parents and some second-time parents in their own homes every year. These include prenatal parents, lone parents and teenage parents. Some are Traveller parents and others are asylum seekers and refugees. In addition, breastfeeding support groups and parent and toddler groups have evolved over the years and they support an additional 600 to 800 parents each year. Outside of the area of the Eastern Regional Health Authority, peer-led interventions operate in another five of the nine Health Boards in Ireland as well as in other countries.

There is great enthusiasm for the Programme everywhere it is in operation. Most new parents who are offered it are delighted to have visits from a Community Mother. There is also a lot more enthusiasm and understanding of the Programme among the Nurse Managers and Public Health Nurses, as well as among other professionals and the Health Board Management, than there was in the beginning. The fact that the Programme has been rigorously evaluated and shown to be effective has greatly helped its general acceptance.

Philosophy and strategy

The philosophy of the Programme is simple but profound. It aims to turn into reality the view that parents are the best experts with their own children, and it works to support the parents in

Profile of a particulary disadvantaged programme site

The Programme operates in many types of areas, including a number of inner city apartment complexes. This particular type of housing was built in the 1950s as an alternative to inner city slum housing. Originally, many of the residents worked in local industries or businesses, which have all but disappeared in the last half century.

Typically, the stairwells in these buildings are dark and damp. There are bare patches of muddy soil in front of the buildings. The gardens of the ground-floor apartments are often used by drug pushers.

The individual apartments have no central heating. The bedrooms are cold, the sitting rooms are warmed by a coal fire, the bedroom walls are damp and crumbling. If it rains, the water often seeps into the apartment. These ill-designed, unheated apartments sometimes house larger families than they were built for. Many of them house lone parents.

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Figures for the area show that over 91 percent of the residents are dependent on welfare. Only 15 percent have taken a state examination while in school, 52 percent are under 25, and around one-third suffer from chronic illness or disability. When you are poor and live in an area like this, your health is more likely to suffer and you will have to wait longer for treatment. Also, your children are far less likely to benefit from education, and therefore a cycle of disadvantage is carried on to the next generation. Integration into broader social networks remains elusive for many citizens who live in areas like this.

These areas are increasingly surrounded by secure apartment blocks bought by young professionals because they are close to the city centre.

achieving the goals they have for bringing up their children. The Programme also tries to avoid any strong emphasis on professional advice, for two reasons:

- First, it has been shown that professional advice given to disadvantaged parents on the rearing, nutrition and health of their children is seldom followed. As a result, some children, for this and other environmental reasons, will never achieve their full potential in life or in the rearing (in turn) of their own children. (WHO/UNICEF 1978, Barker 1987)

- Second, it has been shown in this Programme that if parents living in

> disadvantaged areas can be encouraged to find solutions to their own childrearing problems, if they are given the relevant information on nutritional and health issues and there is no attempt to pressure them to take on particular strategies, most parents will in time arrive at solutions for their children that are effective and which will be applied far more enthusiastically than if the parent were merely obeying/responding to the suggestions of others. (Johnson, Howell, Molloy, 1993)

This empowerment philosophy also means that the home visitor – whether it is a Community Mother or the Family Development Nurse – needs to recognise the parents as equals. The attitudes, the tone of voice, the body language and many other clues quickly tell even the most disadvantaged parent whether or not she or he is being treated with respect and as someone of equal worth and dignity.

In any society in which hierarchical relationships play an important part, it is often difficult at first to convey the reality of this sense of equality to professionals. For some professionals it is easy to adopt this philosophy because they are comfortable with this approach to working with the disadvantaged. For others, it may take training and effort. The small number of professionals who are not able to take on board this kind of equality are not recruited for this sensitive work, since it would affect not only their own visits to the parents but, more importantly, would have an adverse impact on the imparting of this ethos of equality to the Community Mothers throughout their training.

The organisational setup

The CMP is implemented by Community Mothers who are trained and supported by Family Development Nurses.

As the overall coordinator of the CMP, the Programme Director provides support, education and management in the development, implementation and maintenance of the CMP (Johnson & Molloy, 1995). She assists the Family Development Nurses and Community Mothers in a process of mutual learning. The Director is responsible for arranging the conditions and systems within the Programme so that the Family Development Nurses can achieve their own goals by directing their efforts towards the Programme objectives, coordinating the work in the different areas and helping the various teams to solve their own problems by bringing them together on a regular basis. Supervision within the Programme is done through regular evaluation and through a process of mutual and self-criticism. Flexibility of format guides the training/education process.

The successful coordination of the Programme at the level of each Family

Development Nurse is critical to its success. The Family Development Nurse is responsible for recruiting, training, monitoring and supporting a team of Community Mothers. She provides pre-service and in-service training along with a supervisory process for the Community Mothers that fits in with the philosophy of the Programme.

Family Development Nurses are all trained Public Health Nurses who have applied to work with the CMP. Their role in the CMP is based on concepts of partnership and empowerment, promoting participation of clients as well as individual and community self-reliance. It is a move away from 'working **for** people' to 'working **with** people'. This involves a process of 'de-roling', that is, a move away from the biomedical model of health, and it fosters in the Family Development Nurse a commitment to equality in relationships and the development of appropriate skills, such as listening, facilitation, participatory management and evaluation. The training/education process aims to help Family Development Nurses become self-reliant, creative, self-motivating and self-managing, thus helping them reach their own goals and solve, as far as possible, their own problems.

Each geographic area takes full responsibility for its work. The basic principle is teamwork with people accountable to each other in the appropriate spheres of work. A regular cycle of reflection and action ensures that there is an opportunity to celebrate successes, to analyse critically the cause of mistakes and failures and to ensure common goals and values.

The operation of the Programme requires a profound change in the approach of the Family Development Nurse to the Community Mothers and parents. The ultimate goal is to achieve independence of functioning for the Community Mothers and Programme parents, and the Family Development Nurse does this by moving away from the traditional focus in disadvantaged areas: the latest family crisis. She encourages the Community Mothers to move towards a focus on self-development and prevention. From the parent's point of view, the qualities of relationships of equality, trust and recognition of the parents' right to be responsible for the child, serves to capacitate and empower them. They are enabled to cope with problems of childrearing and find their own solutions to their problems, thus reducing their dependence on the Family Development Nurse and Community Mother. This occurs in conjunction with the 'de-roling' of the Family Development Nurse.
The empowering process in the training of the Family Development Nurse combines individual sessions with the Programme Director and group sessions with peers. Equality in relations is enhanced by a one-to-one approach. Once the Family Development Nurse has a basic understanding of her role, she

undertakes Programme visits and starts the development of the Programme. Like the Community Mother, the Family Development Nurse has no model to follow. She learns by her own actions and also from feedback sessions with the Programme Director. The de-roling process for the Family Development Nurse and the development and implementation of a CMP in an area take approximately 18 months to two years.

Recruitment of community mothers

The Community Mothers are recruited as volunteers. A key aspect of the recruitment policy is that the Community Mothers reflect the ethos of the community they intend to visit. They are paid nominal expenses for each visit. This is seen as very necessary as the Programme is operating in working class communities and the small payments are needed to enable the Community Mothers to participate.

In the selection of Community Mothers, certain qualities are sought. These include, for example, a caring sensitive nature, reasonable literacy and an interest in the community. On the other hand, qualities that are deemed undesirable include a dominant, over-confident personality, a tendency to gossip and a woman who perceives herself to be a leader in the community.

When the Programme begins in an area, the majority of Community Mothers are recruited through the local Public Health Nurses. The fact that the Programme is statutory-based and organised by the nursing service accounts for this. The Programme has a continuing recruitment policy and referrals for Community Mothers often come from the Family Development Nurse's nursing colleagues. The Family Development Nurse may also draw on her own contacts if she has previously worked in the area herself.

As the Programme develops, Community Mothers themselves suggest further contacts who might be suitable so that, as the Programme becomes rooted and known in the community, the Family Development Nurse becomes less dependent on referrals from colleagues. In time, parents who have been visited are encouraged to become Community Mothers, thus providing a 'cascade effect'.

In recent years, the availability of paid employment is affecting the recruitment and retention of Community Mothers. But overall, our recruitment methods appear to be successful and, although time consuming, the recruitment process is extremely rigorous.

Training the community mothers

Initial training of the Community Mother by the Family Development Nurse begins with four sessions ofone to two hours over a four-week period. Three of these sessions are on a one-to-one basis at the Community Mother's home and the

fourth session is a meeting with the Community Mothers' group in her area. The training is deliberately kept straightforward and relatively simple. A long period of initial training is seen as undesirable because volunteers need to get started quickly in order to gain confidence in their ability to work with others. The aim of the initial training is to build on the Community Mother's knowledge and skills and to familiarise her with the materials. The training is done in the Community Mother's own home because new recruits may initially lack confidence and thus find it easier to build their confidence in this familiar setting. A further advantage of the home-based approach is that it shifts the power base in favour of the Community Mother.

The training covers the history of the Programme as well as the objectives and values that govern it. Also discussed are the purpose of the home visit and how to approach parents and present the educational material used. After the first four sessions, the Community Mother is ready to make her first home visit, which is discussed between her and the Family Development Nurse.

The Community Mother is then supported and facilitated by the Family Development Nurse until she builds up her visits to between five and 15 families and feels confident in the task. She is also given regular structured opportunities to appraise and reflect on her work. Although

Community Mothers are made aware during training that the Programme is totally confidential except in matters of child protection and that they have a duty to report any child abuse in a way similar to what would be expected of a trusted friend or neighbour.

The empowering process in the training of the Community Mothers is enhanced by a flexible continuous process of training through a combination of individual and group sessions, and a very informal approach is emphasised. One very important factor is that the Community Mother does not see a home visit done by someone else so she does not copy anyone but learns from her own actions. What she does during the early visits is not seen in terms of right or wrong, but how she can build on what she is already doing. This enables her to work within a framework and still develop an approach which is truly her own. The human connection is achieved through common experiences shared by the Community Mother with the new parent. The principles of empowerment that are used as the basis for the Community Mother's training aim to avoid dependency and enable new parents to find solutions to their own problems. When the Community Mother has been in the Programme for six months, she will understand and be able to:

- complete a structured visit to a Programme parent;

- initiate and build a relationship with a Programme parent;
- demonstrate listening skills;
- gain the trust and confidence of a new mother and communicate to the new mother the importance of observation of her baby;
- understand the philosophy of the Programme in relation to equality, empathy and a non-judgemental attitude to parents;
- have a working knowledge of the materials;
- have an understanding of child development;
- plan visits to Programme parents' homes;
- respond flexibly and creatively to any problems that Programme parents may have;
- have information on local health services and other facilities for Programme parents;
- demonstrate commitment to the Programme;
- demonstrate commitment to one's development within the Programme;
- be able to recognise parental stress;
- recognise role boundaries;
- be able to make effective use of supervisory support;
- demonstrate good time-managementskills.

The majority of Community Mothers who have participated for six months or more say that the initial training was of benefit to them, the main reasons being that they are given the information and the confidence they need to start visiting and start to believe in their own worth. They find that the information given is not only factual, but also shows the approach to take when visiting families. As one Community Mother said,

I knew a lot about child rearing but the initial training helped me with my approach, which was to guide parents and not give advice.

Another pointed out that,

It made me realise I had built up a lot of skills rearing my own children. That gave me back my self-confidence again.

Subsequent training for the Community Mothers consists mainly of home-based individual and bimonthly group meetings with the Family Development Nurse. The emphasis is on discussion and the exchange of ideas with the aim of building up confidence and knowledge. The Family Development Nurse acts as a resource

person and works as an equal with the Community Mother.

Being related to a group is felt to be important for support and for generating new ideas and voicing frustrations. A typical response by a person belonging to such a group is,

> *You feel you have someone to go back to if you have problems with the people you are visiting; you don't feel isolated.*

The individual contact with the Family Development Nurse is seen as important to allow Community Mothers to discuss individual problems.

It is encouraging to see that the Community Mothers feel they are given the opportunity to learn and have benefited from their training experience. In the words of one Community Mother,

> *You learn a little at a time but more all the time. The Programme appears to be about being positive and building up one's knowledge and skills.*

Programme materials

Over the years the CMP has developed a number of materials for use in the Programme. Particularly important are the illustrated sheets that demonstrate key aspects of childrearing. The sheets used were initially the cartoons from the UK-based Child Development Programme, but feedback showed that these were not culturally relevant and needed to be updated. Over a five-year period, a working group developed new sheets based on input and continuous feedback from Programme parents, Community Mothers and Family Development Nurses. These sheets are used as 'triggers' for discussion during the home visits and present a variety of issues in ways that are comprehensible and non-threatening.

The home visit

The monthly visit to the family is the main focus of the Programme and can be adapted to the circumstances of individual families. The issues discussed at each visit are tailored to the particular needs of the family and the approach is supportive of the parent's own ideas and recognises each parent's desire to do what is best for his or her children.

The Community Mothers attempt to visit parents for one hour each month, by appointment, up to the child's second birthday. The reason for having one-hour visits is to enable topics to be discussed in depth while ensuring that visits are structured to meet individual needs.

Each visit starts with the Community Mother noting on a developmental card any new development that the parent has observed in the child over the past month. She enquires whether the parent has managed to try out the various developmental ideas discussed at the previous visit. This is intended to increase the parent's confidence and self-esteem. The parent is asked about new ideas and

strategies she has tried out which may be helpful to other mothers.

Some three or four of the illustrated sheets are given and discussed at every session. These are important for assisting the sharing of ideas between the Community Mother and the parent. A 24-hour diet recall is recorded for both the child and mother. A brief enquiry is made about the child's health over the previous month. This is combined with the mother's report about any visits made with the child to the clinic, doctor or hospital and the mother's own estimate of the child's health. Finally, the mother is asked what she would like to try out in the following month and she is invited to suggest her own ideas, which are written down on a Child Progress Form and on a Suggestion Form, which is then left with the mother. The Child Progress Form helps to structure subsequent visits.

Rather than the baby being the focus of the visit, as is usually the case when a professional does a home visit, the mother is the focus of the Programme visit. The Community Mother encourages the Programme parent to think of her as a friend. As such, the whole approach is different from that of a professional who the mother might see as 'coming to check up on her'.

The illustrated sheets are the chief method for encouraging learning and they serve to identify ways of dealing with difficulties in child rearing. They allow the mother to view a problem she may have *through the eyes of another woman.* Therefore, the discussion is not directed at her personally and it is thus easier for the visitor to analyse the issue and discuss its implications with the mother. The mother is not judged or criticised but is praised for her efforts and her ideas are valued at all times. The uniqueness of every parent, mother or father, is always recognised. If the Programme offered uniform support, or gave the same illustrated sheets to everyone, its effectiveness would be seriously impaired.

Programmme parents

Parents are offered the CMP by the Family Development Nurses in their area. Each Family Development Nurse receives a list every month from the local health administrative headquarters with information on the births in that area, the date of birth, and whether this is a first birth. In a few cases, for example, when they have just moved into an area, parents are referred to the CMP by Public Health Nurses. For reasons of confidentiality, lists of prenatal parents are not provided by the maternity hospitals, but Family Development Nurses have access to outreach clinics in the community and can offer the programme and breastfeeding information prior to the birth. In addition, once the Programme is established in a community, Community Mothers informally identify mothers-to-be.

Of all the parents who are offered the Programme, approximately two-thirds accept it. The main reasons for not accepting it are that the parents are returning to paid employment, they are intending to move from the area in the near future or they are not interested in taking part.

Fathers

Fatherhood is increasingly emerging as an issue in family support policy and practice, both nationally and internationally. Promoting the father's greater involvement in childcare is now acknowledged as being beneficial for children. Until recently, little attention was paid to the role of the father in Ireland and there was little research into their parenting support needs or what they thought about parenthood. The National Children's Strategy (Department of Health and Children, 2000) stated that the role of fathers was mentioned in only a very small number of the submissions made to it by the organisations invited to contribute.

Traditionally, fathers have provided economic support for their families but tended not to be involved in the day-to-day responsibilities of childrearing. Consequently, services and support for fathers are poorly developed. The Irish Constitution makes no reference to fathers and, unlike mothers, they do not have a constitutionally protected right to their children. The position of unmarried fathers is particularly weak. In the CMP, efforts are made and have always been made to involve fathers as much as possible.

Community Mothers discuss with mothers, and fathers if they are present, how fathers can be encouraged to play a greater part in the rearing of their children. The majority of visited parents are mothers, although a small minority of fathers have taken part over the years. These have mainly been fathers who are engaged full-time on 'home duties'. All those fathers who have accepted the Programme have completed it and have stated that they have benefited from a one-to-one relationship with a Community Mother. In situations where a particular mother shows, over an extended period, that she has little interest in the Programme, a Community Mother will then focus the Programme on the father if he is willing. The ideal situation is when both parents play an equal part, not only in the Programme, but also in the rearing of their child and in the work to be done in the home.

The higher uptake of the service by mothers is not surprising for another reason. The majority of the mothers in the Programme are on 'home duties' or are engaged in part-time employment. So it is easier for them to access and take part in the Programme, which operates mainly during the day. Although some Community Mothers visit in the evening and/or at weekends, the majority fit their

Programme visits around their own and their family's commitments. Safety is also a consideration with evening visits in some areas.

One area where a lot of thought has gone into involving fathers is in the Programme materials. The illustrated sheets reflect changing family patterns and are very inclusive of fathers.

Empowerment

Empowerment is a process by which individuals, groups and communities become able to take control of their lives and achieve their own goals, thereby being able to work towards maximising the quality of their lives. It is accepted that there is a broader socio-economic context of poverty and social exclusion, which has an impact on the process of empowerment.

The CMP targets the disadvantaged, many of whom are living in relative poverty. Poverty and the accompanying economic deprivation can have a detrimental effect on health; for example, it can make it difficult to provide a healthy diet and to adopt a healthy lifestyle. Poverty can cause stress, which can be exacerbated by racial discrimination, and can lead to feelings of powerlessness, paralysis and resignation.

The CMP uses the 'empowerment model' and this reduces the parent's dependence on professionals. This empowerment is achieved by

- drawing out the parents' potential rather than by giving advice and direction;
- using a behavioural approach in which parents are encouraged to undertake agreed-upon tasks;
- showing the alternatives available to parents in coping with various childrearing problems through the use of illustrated sheets.

The Programme visit is an empowering process in action in that parents are encouraged to identify their own issues and concerns, recognise their assets and find solutions that fit their particular needs. They are encouraged to acquire the confidence and skills to take action and make appropriate interventions. The results of the 1990 evaluation of the Programme confirmed that the empowerment model of developing parenting skills was effective (Johnson, Howell and Molloy, 1993).

The CMP can only be effective as an empowering programme if all the people involved are empowered: the professionals, the volunteers, the parents and, ultimately, the communities themselves. To this end, working relationships in the Programme are based on partnership and participation. Relationships of this nature are perceived as desirable empowering strategies. The Family Development Nurses, as empowered

employees, have the authority to do their job and use their initiative, and they often go beyond the call of duty. They are freed from rigorous control, given the freedom to use their energies and abilities and allowed to take responsibility for their own ideas, decisions and actions.

Summary of key elements

Experience has shown that the CMP works because it is based on a number of key elements.

A clearly structured format in which written forms help guide both the Community Mother and the parent being visited. The forms are related to the behavioural theory that underlies home visiting and include a written agreement setting out what the mother has decided to try out in the following month. This is, in itself, a powerful incentive for the mother to actually try out these new ideas. The forms also concentrate the Community Mother's attention on the purpose of the visit, namely, to identify what the parent wants to achieve, as well as assessing the child's health and general progress.

A one-to-one relationship between a trusted visitor and the parents in which parents are supported and their skills developed in their own home. The privacy, and the fact that the parents are in control in their own home (provided the philosophy of the visit is carried out), enable the parents to achieve a great deal. A parent who has been supported and strengthened in this way is more likely to succeed in any group sessions she or he might attend later on.

A fundamental and clear equality between the Community Mother and the parent being visited. An unequal relationship could prevent the Programme parent from realising her potential, which is one of the most basic goals of the Programme. It is for that reason that the creation and maintenance of a relationship of meaningful equality is another central principle of the Programme.

The use of illustrated materials helps to soften the impact of discussing difficult behavioural issues with parents. For example, it requires great sensitivity to discuss with a parent the consequences that may arise from her treatment of her children. But with an illustrated sheet this is made much easier because the Community Mother does not see herself in an official role, but rather as a supportive and empathetic friend. In such a situation, illustrated sheets may be used to show both effective and ineffective ways of coping under stress or of achieving some childrearing goal. They provide an easy, non-threatening and relevant way of raising difficult issues and discussing them, and are also easily understood because of their simple and direct style.

The Library:
A Source of Delight.

ONE MORNING...
Oh, so that's where the local Library is. I wonder if they have anything interesting.
LIBRARY
INSIDE THE LIBRARY...
Wow! I never thought that a Library was such an interesting place. I must tell Sheila.
I've found some books for myself but could you help me find something that will interest the baby?
Sure. Come with me and I'll show you the children's section.
He's really enjoying himself I must bring him every week. Just wait till I tell Sheila. Her baby would love this.
CHILDREN'S SECTION
LATER, AT HOME...
You didn't bring the baby, did you?
Sheila, he had a great time and so did I. Listen, I'll call in for you next week and we'll go together.

Previous evaluations

Evaluation of the community mothers programme 1990

An evaluation of the effectiveness of the Community Mothers Programme was carried out in 1990 (Johnson, Howell and Molloy, 1993). The method used was that of a randomised controlled trial in which a number of first-time mothers who were eligible for the Programme were randomly assigned either to an intervention group that received the Programme or to a control group that did not. Both groups were assessed at the child's first birthday.

The study involved 232 first-time mothers resident in four working-class areas of Dublin. All the mothers received the standard support from the Public Health Nurses. They also all received invitations for primary immunisations and developmental assessments of their babies. The 127 'intervention' mothers also received the support of a Community Mother. There were thus 105 mothers in the 'control' group.

Table 3.1 shows the socio-demographic breakdown of the two groups. There were no significant differences between them except for the employment status of both mothers and fathers ($p=0.05$). The mothers in the intervention group were more likely to be employed than the mothers in the control group (29 percent against 17 percent), while 51 percent of the fathers of babies in the intervention group were employed, as against 33 percent in the control group.
Table 3.1: Socio-demographic profile of participants in the 1990 evaluation

Of the 127 mothers in the intervention group, 82 (65 percent) received at least 10 monthly visits from their community mother, 34 (27 percent) received between five and nine visits, and 11 (9 percent) received fewer than five visits.

Baseline statistics were collected at the first visit and a simple evaluation questionnaire was developed and completed on the child's first birthday. All information was collected by the Family Development Nurses. The questionnaire included questions on demography and environmental factors; mother's self-esteem; medical items, including immunisations and hospitalisation; nutrition of both mother and child and developmental stimulation factors.

One of the major objectives of the CMP is to improve the self-esteem of parents. In order to measure the extent to which this had happened, four aspects of the mother's self-esteem were measured by asking about tiredness, headaches, feeling miserable and a desire to stay indoors. The nutrition of both mother and child was assessed by asking the mother to recall her own diet and the

cartoon: Artwork and layout: Gordon Harper, © 2000 Community Mothers Programme

TABLE 3.1: SOCIODEMOGRAPHIC PROFILE OF PARTICIPANTS IN THE 1990 EVALUATION

	Intervention group N = 127		Control group N = 105	
mean age of mother (years)	24.1		23.1	
Mean age at which mother left school (years)	15.9		15.7	
	number	**percent**	**number**	**percent**
mothers' marital status:				
unmarried	65	51	64	61
married	61	48	40	38
separated	1	1	1	1
mothers' employment status:*				
employed	37	29	18	17
unemployed	90	71	87	83
father's employement status:*				
employed	65	51	35	33
unemployed	34	27	36	34
unkwomn	28	22	34	32
housing:				
private	56	44	38	36
local authority	71	56	67	64

*Significant at p = 0.05

diet of the child during the preceding 24 hours. Advice from a dietician allowed the responses to be categorised as appropriate or inappropriate. 'Inappropriate' intake meant that there was not enough, or too much, of a particular food. The duration of breastfeeding was established, as was the duration of formula feeding anc the age at which cow's milk was introduced.

Three areas of the CMP were implemented with the aid of specially designed illustrated materials. These were educational development, including early reading to the child; language development, with

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nursery rhymes being seen as part of the stimulus for developing early language; and cognitive development, including the use of games. Mothers were asked how often they read to their child, what type of games they played with them, and the extent to which they used songs or nursery rhymes. The question on games invited parents to state which particular games they used with their children, and each game they mentioned was recorded. The games were then divided into 'cognitive games', which included hide-and-seek, singing games and number games, and 'motor games', which included floor games or games using a ball. The games in each section were then totalled.

Finally, in an attempt to measure general morale and well-being, mothers were asked about their feelings during the year since their child was born. Replies were recorded as being either positive or negative. An example of a reply that would be counted as positive is, *I enjoyed every day, and watching the baby come along was a great experience.* An example of a reply that would be counted as negative is, *Terrible, I found it hard to cope.*

Findings

The results of the randomised controlled trial showed significant differences between the intervention group and the control group (by 'significant' we mean that we are at least 95 percent sure that the difference is not due to chance). The intervention group scored significantly better than the control group in the following areas:

- immunisation of the child;
- diet of both mother and child;
- length of time child fed formula;
- time of introduction of cow's milk;
- reading to child;
- language, educational and cognitive development of the child;
- maternal self-esteem.

On **immunisation,** 77 percent of all the children had received all three shots of their primary immunisations by their first birthday. The intervention group performed significantly better than the control group ($p=0.001$).

Children's **diet** was assessed according to the length of time that they were kept on formula and breastfed, the age they started on **cow's milk**, and by a 24-hour recall of diet provided by the child's mother. It was found that mothers in the intervention group kept their children on formula significantly longer than those in the control group ($p=0.001$). Also, control group mothers were more likely than intervention group mothers to introduce cow's milk before 26 weeks

(p=0.0001). (At the time of the study, there was a policy not to introduce cow's milk until the child was six months old. This has since been raised to 12 months.) For all food groups (protein, whole foods, vegetables, fruit, milk and energy intake) both children and mothers in the intervention group performed significantly better than those in the control group (children at p=0.001 and mothers at p=0.01).

Where the child's **development** was concerned, 78 percent of all the mothers said that they read to their child. Ninety-eight percent of the mothers in the intervention group read to their child, compared to 54 percent in the control group (p=0.0001). On the question of reading to the child every day, 56 percent of the intervention group did so, compared to only 26 percent in the control group (p=0.0001). Scores for 'cognitive games' and the saying or singing of nursery rhymes were significantly better in the intervention group (p=0.01), although no difference was found as regards 'motor games'.

Table 3.2 shows the four indicators that were used to assess the levels of self-esteem of the mothers when their children were 12 months old. In three of these areas – tiredness, feeling miserable and wanting to stay at home – the intervention group scored significantly better than the control group. There was no significant difference between the groups with regard to the frequency of headaches. The intervention group also had a higher score for positive maternal feelings and a lower score for negative feelings when these were evaluated at the time of the child's first birthday.

There was no significant difference in the proportion of intervention and control children admitted to **hospital** during the study, but of those children admitted to hospital, the mean length of stay for the intervention group was 14 days, which was significantly greater than the mean stay of seven days for the control group (p=0.05). Children in the intervention group were less likely to have an **accident** requiring a visit to hospital (three children in the intervention group and eight children in the control group). There were three cases of **child abuse** among the control group, against none in the intervention group.

Discussion

There were several favourable outcomes for the mothers and children who were part of the CMP. For the mothers, when compared with the mothers in the control group, there were encouraging results in the following areas: maternal self-esteem, maternal and child nutrition, developmental stimulation, and maternal morale and well-being. So far as the children were concerned, the children in the intervention group were more likely to be immunised, duration of breastfeeding tended to be longer, their general nutrition was better, and they were less likely to have an accident, compared to control children.

TABLE 3.2: MOTHERS' SELF-ESTEEM ON CHILD'S FIRST BIRTHDAY, 1990 EVALUATION

	Intervention group N = 127		Control group N = 105		
	number	percent	number	percent	p.Value
tired:					
yes	99	78	95	90	0.01
no	28	22	10	10	
headaches:					
yes	62	49	52	50	0.92
no	65	51	53	50	
miserable:					
yes	73	57	80	76	0.003
no	54	43	25	24	
staying in:					
yes	40	31	57	54	0.001
no	87	69	48	46	

The Programme failed to show any benefit in terms of hospitalisation. Although the median length of stay of those intervention children who were admitted to hospital was greater than for the control children, upon examination, it was seen that intervention children suffered from an assortment of common childhood conditions that were not addressed specifically by the Programme and which the Programme could not be expected to influence to a significant degree.

Because of limited resources, we were not able to employ independent data collectors. The Family Development Nurses administered the questionnaire and, although the possibility of bias cannot be entirely ruled out, cross-checking of mothers' responses on immunisations with Health Board records did not reveal any discrepancies.

In conclusion, the empowerment approach to developing parenting skills was found to be effective. Also the fact that the Programme can be delivered by non-professional volunteer mothers working in partnership with Family Development Nurses is very positive.

The strength of the association between favourable results on a number of outcomes and membership of the intervention group were impressive.

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Community mothers programme: extension to the travelling community

In 1992, the CMP was extended to the Travelling community and a study to see whether the Programme could be extended successfully to the Travelling community was carried out in 1996 and published in 1997 (Fitzpatrick, Molloy and Johnson, 1997).

Travelling people are an indigenous minority in Ireland, numbering 4,978 families in 1998. They have been part of Irish society for centuries. Travellers have a unique shared history and value system, which makes them a distinct group, and they have their own language, customs and traditions.

The Traveller group studied comprised 39 mother-and-child pairs who had received the CMP. This group was compared with the 1990 study discussed in the preceding section, where there were 127 non-Traveller intervention mothers and 105 non-Traveller control mothers.

All the mothers received the standard support from a Public Health Nurse. In addition, the non-Traveller intervention mothers and the Traveller mothers received the Programme visits from Community Mothers. The socio-demographic profile of the Traveller mothers differed significantly from the non-Traveller groups. For example, the Traveller mothers left school earlier and 95 percent of them lived in caravans. Over 80 percent of the Traveller mothers used an outside tap and 40 percent had no access to a toilet. Just under a third had no electricity and 84 percent had no garden.

It was found that the children of the Traveller group and of the intervention group were exposed to more cognitive games and nursery rhymes. Children in the Traveller group were less likely to have completed their primary immunisation coverage (with 56 percent immunised), compared to both the non-Traveller intervention group (87 percent immunised) and the non-Traveller control group (65 percent immunised). The diet of the Traveller children surpassed that of the non-Traveller control group in all food groups except fruit, and they were less likely to be given cow's milk before 26 weeks of age. The Traveller mothers' diet was similar to that of the non-Traveller intervention group and was better than that of the non-Traveller control group. Traveller mothers and the non-Traveller intervention mothers had a higher self-esteem profile than the non-Traveller control mothers.

The overall results of the CMP in the Travelling community were very encouraging, with immunisation coverage remaining a challenge.

Effects of participation in the CMP on community mothers

Contemporary literature suggests that social support has a positive effect on

those receiving it, but there is also a growing awareness that supportive exchanges can be of mutual benefit to the lay people involved in providing it (Johnson and Molloy, 1995). One study (Molloy, 1992) examined the effects on Community Mothers of their participation in the CMP and also looked at sub-groups who had worked with the Programme for varying lengths of time to see if there were any differences or similarities between them.

The study was designed to identify the factors influencing application and acceptance for recruitment, the personal and social effects of Programme involvement on the Community Mothers, the nature of the relationship between the Community Mothers and Programme parents, and the benefits or otherwise of pre-service and in-service training.

Interviewer-administered questionnaires were used for data collection. Demographic and social characteristics were recorded, together with information on the perceived benefits to the Community Mothers, the effects of training, and relationships with Programme families and colleagues, as well as changes in attitude toward, knowledge of and status in the community as a result of involvement in the CMP. (Some of the findings of this study have been included under the relevant sections in Chapter Two.)

It is important to recognise that the findings of the study apply only to Community Mothers in Dublin; it cannot be assumed that they are representative of volunteers involved in similar support interventions elsewhere.

Summary of findings

It has been reported in the literature that the typical volunteer is female, middle class, middle aged (in the 40 to 60 age group) and married (Molloy, 1992). The Community Mothers do not fit this pattern. At the time of the study, approximately 80 percent of them were between the ages of 25 and 44 years, with the remainder in the 45 to 54 and 15 to 24 age groups. Two factors that may influence the younger age of the Community Mothers could be the nature of the voluntary activity and the tendency for parents who have been in the Programme to become involved as volunteers themselves.

Similarly, the social class of the Community Mothers did not fit the pattern of the typical volunteer. Going by the Government system of classification and based on their partners' present or previous occupation, the majority of Community Mothers were classified as working class. The Community Mothers reflect the areas where the Programme operates – these have been labelled 'disadvantaged' in socio-economic terms.

The majority of Community Mothers were married. In this they are similar to the typical volunteer identified in the literature but different from the

Programme parents. Over 50 percent of the Programme parents are lone parents. The majority of Community Mothers had between one and three children. The study found that 47 percent of the Community Mothers left school without taking a state examination.

Just under half the Community Mothers in the study were living in local authority rented accommodation and just over half were entitled to the full range of medical services without charge, which indicates that they had low incomes. Just over half were living in private accommodation, which suggests that they were firmly established in the community, with a number having opted to buy their homes from the local authority. The majority were married to men who were employed. In this, they did not appear to be representative of the areas that the programme is operating in, where unemployment is still a factor.

Motivation

Over half the Community Mothers gave altruistic reasons as their motive for joining the Programme, with only a small minority giving personal gain as their main reason for joining. This need to help others appears to be rooted in culture, tradition and in working-class experience and involves caring based on empathy rather than on doing good. The majority of the Community Mothers were supported in their volunteering by husbands, children, relatives and friends who could see the value of helping others and who also felt that the Community Mother might have a need for developing an identity outside of the home. The Programme appeared to be mobilising not only the 'natural helpers' but also new helpers who, through their involvement in the Programme, felt confident about getting involved in other community endeavours.

A number of Community Mothers mentioned how they felt when they were first-time parents; they remembered the difficulties they experienced in bringing up their own children and the loneliness and isolation they had felt at this time. As one Community Mother said,

> *The main reason I got involved was that I could be of help to somebody else if they were lonely, or whatever, because I remember when I had my first baby and was living in a new housing estate.*

Others stated they just liked helping, which is altruism based on personality. Typically, such a person would say,

> *I have always had this thing inside me where I would like to be helping and doing something for others.*

None of the Community Mothers stated that they see helping as a social duty, giving from a higher level to a lower one, which has been shown can be a factor in more middle-class neighbourhood care schemes.

For those Community Mothers who talked about the need to meet people, or who said they had time to spare, or who identified with the aims of the Programme, there was also an expressed desire for independence that comes through participation in the Programme. They were often looking for a sense of personal identity outside of their home and family, so that participation could function as a diversion or a therapy. As a person with such a need said,

> *I was busy at home but I wasn't meeting anybody. My life wasn't going anywhere and I had lost my self-confidence. I wanted to meet people.*

A number of parents who had themselves been visited later became Community Mothers because they were motivated by a desire to help others in the same way that they felt helped. As one such woman commented,

> *I had the Programme myself and I liked getting praise for the things I did even when nobody else praised me. I decided that other people should get the same, so the reason I am involved is to give back what I got out of it.*

The main focus for the interviewees was not the formal organisation to which they were linked; 96 percent of them stated that they identified with the community rather than with the Health Board. This was a positive finding, particularly as the CMP is based in a statutory organisation and thus runs the risk of professionalising the Community Mothers.

The majority said that if they had a choice, they would still continue to live in the area. The Community Mothers clearly identified with, and were rooted in, their community, and this could be an important factor explaining why they were willing to help others in the community. While recognising that the Health Board has a role to play in facilitating the Programme, they prioritised the needs of the community. As one said,

> *The Health Board gives us the official backing. It kind of sets the ball rolling but it is the community that keeps the ball rolling.*

Relationships with visited families

The Community Mothers were positive about the relationships between them and the families they visited. Comments included such statements as,

> *I get on with them and they make you feel so welcome. If they ask you questions about something, you are delighted, especially if you have the right answers. I feel very positive about it.*

The Community Mothers saw themselves relating to parents as 'ordinary' women and not as 'mini professionals'. Being able to share their own difficulties in rearing their own children with the Programme parents may be another

factor in the development of a positive relationship because Community Mothers, unlike professionals, do not have to remain objective with families. As one Community Mother commented,

> *You can understand when the mother says, 'I feel like strangling her.' You can say, 'Yes I know. I have felt like that myself.'*

A theme running through this feedback is the notion of mutual benefit, or the exchange in the relationship, which could be positive from both the Programme parent's point of view and the Community Mother's, for example, the development of friendships or the sharing of difficulties. So, what appears to be altruism is often linked to reciprocity, with both parties gaining from the relationship.

Difficult families

While Community Mothers generally described their relationships with Programme families as positive, there were difficulties that they had to deal with. The main one was having a child's grandmother present during a visit. There is a bond between mother and daughter in working-class communities where there is a tradition of a daughter drawing on her mother's knowledge, particularly if she lives near her mother. The daughter has a lot to gain from this relationship and often nurtures it. But ideas on childcare can change, which can cause the grandmother's skills to become obsolete. The daughter may want to update their information and so is willing to accept guidance and support from outsiders, which may cause some tension between the Community Mother and the grandmother, who might see the Community Mother's visit as a threat. One Community Mother said,

> *Some of the grandmothers are overpowering. They don't believe in immunisation and they think their ways are best. So it is hard to get to the mother. They will interfere, saying that they have reared their own children and have given them such and such in their bottle at night and it didn't do them any harm.*

Resistance to the Programme is expressed by parents in a number of other ways, by not keeping appointments, for example, or by appearing to block the Community Mother or not appearing very interested in the Programme. It could be that the Programme parent is testing the sincerity and commitment of the Community Mother or the parents are wary because they may feel that it is just another official service, particularly as it is facilitated by the Health Board.

Only a small minority of Community Mothers reported that dealing with the personal problems of the parents was a difficulty. Those who found it difficult appeared to have been guided by the

principles of the Programme. As one of them said,

> *The mother was telling me about her marriage problems and did not appear interested in the Programme and I found her hard to deal with. I felt that I wasn't experienced enough and that it wasn't my business to interfere in someone else's marriage problems. I just said to her one day, 'I hope you'll make the right decision.' Eventually she said that she did.*

Personal changes

Involvement in the Programme affected the Community Mothers in several ways. They had developed friendships with their Community Mothers and their Family Development Nurse colleagues, the social milieu of the project being a source of benefit. For a minority, their relationship with their husband had improved, with the relationship now being felt to be more respectful with more open communication. Three-quarters of the Community Mothers stated that their relationship with their children had improved because they were now more aware of their children's needs, listened to them more, understood them better and had more patience with them.

A number of factors appeared to have contributed to this, including increased self-confidence, and they used the strategies and knowledge gained in the Programme with their own children. The majority also said that they had introduced changes in their childrearing practices, especially in relation to new knowledge they had acquired about nutrition, discipline and early childhood care and education. The main new skills cited were listening, communication and parenting skills. The majority also felt that they now had more knowledge about health topics in general.

The majority of Community Mothers also noticed differences in themselves, particularly increased self-confidence and greater self-worth. This appeared to be related to the acquisition of new knowledge and the development of socially useful skills. It also appeared to be related to the role of women in society with housewives seeing themselves as having low status. Over half stated that they now felt more in control of their lives, that they could now deal with those in authority better because of increased self-confidence and knowledge, and that they felt they now had more power in relation to their community and they could influence the community in their role as a Community Mother. Only a minority felt the need to get involved in pressure groups and/or political organisations.

Just under half of the Community Mothers were thinking about taking on paid work, and the majority felt they would still be involved in the CMP and

other community activities in five years' time. Overall, their main reasons for continuing were similar to their reasons for joining the CMP.

Some differences were noted between the sub-groups of Community Mothers who had worked with the Programme for varying lengths of time. Some of these differences were felt to be related to their length of service, with the Community Mothers becoming more confident and comfortable in their role as time went on. This was noted in the areas of relationships with Programme families, self-empowerment and changes in relationships with their children.

Differences were also found in the sub-groups of Community Mothers who had less experience, and these differences were felt to be due to the Community Mother's initial enthusiasm and, in some cases, to her inexperience and lack of confidence. This was noted in the areas of self-esteem, their relationships with Programme families and changes in relationships with their children and husbands.

Just over half of the Community Mothers felt that they had more control of their lives since they became involved in the Programme. This was felt to be related to a number of factors that included being better organised by having to plan out what they intended to achieve. The women said that better organisation was necessary in order to do the Programme work. Responses included statements such as,

> *I'm better organised now, I write everything I plan to do in my diary. I have to work out a system in order to be able to keep my appointments with the families.*

> *I plan what I'm going to do now, whereas before I just got up on that day.*

Time can be long for women in disadvantaged areas (Johnson and Molloy, 1995). The routine activities for daily living take little time and are completed without reward, enjoyment or stimulation. Being involved in the Programme appears to change all that. It is a resource for the Community Mothers to use for the community and it brings its returns, for example, self-enhancement and satisfaction.

Conclusions

Overall, the majority of Community Mothers had benefited in many ways from their involvement in the Programme, and these benefits showed themselves from six months onwards. The study showed that Community Mothers had benefited through a process of human development that contributes to social and mental well-being. The relationship between Community Mother and

Programme parent is one of reciprocity: each contributes to the other's needs.

The study results suggest that with appropriate back-up so that they can receive as well as give, it is possible to involve volunteers more in primary relationships with families.

The volunteers in the Programme are all mothers. One school of thought sees this as negative – seeing women as being asked to shoulder the main burden of care within the community both as kin and as volunteers. Others would argue that community action is an area particularly central in the struggle for women's emancipation and would stress not only the possibility of achieving specific targets but also the importance of process. In becoming involved with community action, women begin to challenge not only the social definitions of their role but also internalised perceptions that may serve to limit their self-expectations. So it could be argued that women's voluntary action is motivated by a feminist awareness and is the creator of a wider awareness.

Community Mothers appeared to recognise and value their work and skills in the community context. As women and as mothers, they felt they had something to offer and could contribute to family and community development. They also said that seeing how other people lived made them more aware of their own lives and made them feel that they could improve their lives. One said,

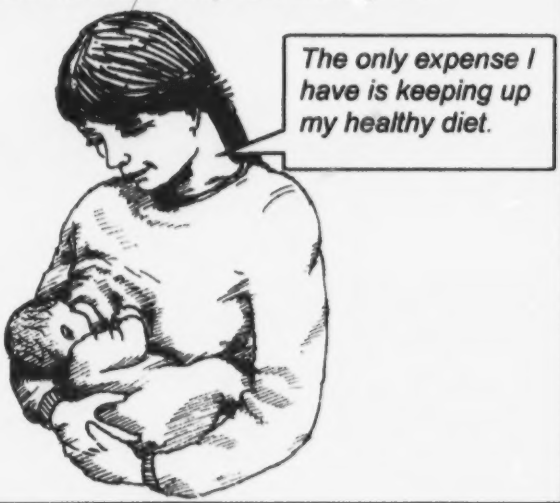
> *I've got to the stage where, now that I feel I'm a person, I want to move ahead and make life more positive for myself and my children.*

They also said that they now feel that they can do things they want to, not just for their families but also for themselves. As one Community Mother put it,

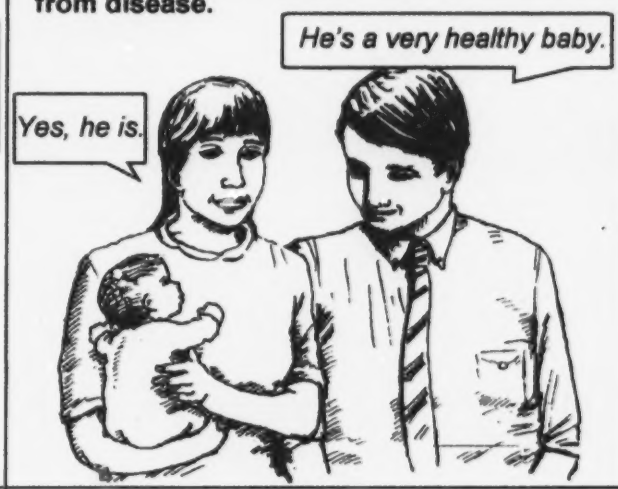
> *I'm a person again. I have self-worth. I have my opinions now and I stick to them.*

It makes good sense for a mother to breast-feed her baby. This is because:

1. Breast-milk comes free of charge.
Remember, however, that a breast-feeding mother needs to keep to a healthy diet.



2. Breast-fed babies tend to be fitter and healthier.
Breast-milk gives babies more immunity from disease.



3. Many mothers find that breast-feeding helps to develop emotional closeness with their babies from an early age.

4. Breast-feeding helps a mother to get back her figure following her pregnancy.

NOTE

If you experience problems in breast-feeding, such as sore nipples or too little milk, ask for support from your Public Health Nurse or another mother who has breast-fed successfully.

The seven-year follow-up study

In 1997, a follow-up study (Johnson et al., 2000) was undertaken in which we attempted to trace the mothers and children who had been part of the 1990 study described in Chapter Three. By then, the Programme children were eight years old.

The follow-up study was done because an important consideration of an effective intervention is whether the positive effects last or are 'washed out'. By tracing the same mothers and children who had been in the 1990 intervention and control groups, it would be possible to discover whether the benefits of the intervention were still evident.

The 'gold standard' for providing answers on whether interventions work is considered to be the randomised controlled trial. In this approach, a carefully drawn sample population is divided randomly between an intervention group and a non-intervention group. Key baseline information is collected about the functioning of the two groups of people, the intervention is made, and the populations are measured again. This type of research design makes it possible to argue that significant differences that are found can be attributed to the intervention because the two groups are similar in other respects.

The Community Mothers Programme had been rigorously evaluated using a randomised controlled approach in the 1990 study, when the children were one year old, and there was sound evidence then that it was effective (Johnson, Howell and Molloy, 1993). A follow-up study would, however, strengthen the findings.

Methodology

A working group consisting of the Director of the CMP, two Family Development Nurses, a Community Mother, a social scientist and two public health specialists met several times to work out a strategy for the research. Most of the group had some knowledge of the CMP and had an interest in the area of parent support. The inclusion of a Community Mother was very positive because she was very aware of what needed to be included in the study.

When developing the interview questionnaire, it was necessary to establish outcome measures that would be in line with the operation, philosophy and effects of the original CMP. We had found little literature to help us with the 1990 study, and as a consequence, there was no established method for doing this follow-up study. It was therefore necessary for us to develop our own

cartoon: Artwork and layout: Gordon Harper, © 2000 Community Mothers Programme

approach. In our favour was the fact that the 1990 study was properly randomised using standard methods, and the response rate had been good.

In designing the questionnaire we did all we could to keep the wording as simple as possible while attempting to avoid loss of accuracy. The concept of limiting the number of ideas contained within a question to one was adhered to so far as possible. This was to ensure that the questionnaire was relevant and easy to understand.

The finished questionnaire (see Appendix) consisted of 40 questions and addressed the following areas:

Demography: This included the age and the sex of the child; the age, employment and marital status of the mother; and employment of the partner. Information was also collected on housing (whether it was rented or owned), car ownership, telephone service, central heating, and whether or not the family had their own garden.

Child health: Information was collected on primary immunisation coverage and boosters, accidents, illnesses, hospitalisation and dental check-ups.

Nutrition: Nutrition of both mother and child was assessed by using a 24-hour dietary recall for both mother and child. The diet was categorised as appropriate or inappropriate following advice from a dietician.

Parenting skills: Information was collected on whether the mother read to the child, whether the child enjoyed reading, and on library use by both mother and child. Families were also asked about supervision of television viewing (with viewing of horror videos an indicator of lack of supervision), enjoyment of school, bullying at school, checking of homework, discipline and awareness of children's friends (as an indicator of involvement with children). Mothers were asked whether they agreed or disagreed with a series of statements that addressed attitudes about the discipline of children and parental involvement in children's activities.

Maternal self-esteem: Four aspects of the mothers' self-esteem were measured by asking about tiredness, headaches, feeling miserable and a desire to stay indoors. The Rosenberg Self-Esteem Scale (Rosenberg, 1965) was also used. Agreement with statements that suggested positive self-esteem was given a score of 1, whereas other responses were given a score of 0. A total score was then produced for a respondent by adding up the individual components. The maximum possible score available to respondents was 9 and the minimum was 0. Both the intervention and control mothers were also asked how they felt about being a mother now that their child was eight years old. As in the 1990 study, each positive feeling expressed by the mother was given a

score of 1, as was each negative feeling. Scores were totalled separately to get a total positive score and a total negative score for each mother.

Impact of programme on subsequent children: Mothers in both groups were asked about breastfeeding and immunisation of subsequent children, and also whether their learning experiences during the eldest child's first year helped with subsequent children.

The draft questionnaire was tried out with a small group of parents and was then revised to ensure clarity of meaning.

The survey

The main survey work was carried out in 1998 in four areas of Dublin, and for this study, an independent data collector was used. It was difficult to get in contact with the mothers for a number of reasons. The areas covered by the Programme are very disadvantaged, and if people get the opportunity, there is a lot of movement out of these areas. Also, many of the mothers in the 1990 study were not married; if they had subsequently married, they would probably have moved to another address and changed their names.

If it was not possible to make contact with the mothers on the first visit, up to five further visits were made until the mother was contacted and an interview could be carried out. Some mothers were traced through a street directory from which it was possible to find out whether or not the mother herself or a member of her family was still living at the address given during the 1990 study. It was possible to reach some of mothers through their medical registration. People who are eligible for free medical services in Ireland are entitled to a medical card, and the name and address of the cardholder is kept on computer by the Health Board. This was used to confirm a number of addresses found in the street directory. If the mother was no longer living at the address, a forwarding address was obtained from the new residents, if possible. This was not very successful. Some of the residents were suspicious of our motives, and apart from family members, all of those contacted who were living at the address were either unwilling or unable to supply a forwarding address.

At one point it was thought that the study might have to be abandoned because the number of mothers contacted was not sufficient. The working group discussed the issue and it was decided that the Director of the CMP should travel with the data collector to the areas each evening to see if more mothers could be interviewed. The knowledge of the Family Development Nurses and Community Mothers of the different areas was invaluable at this point because a number of the areas were unsafe for non-residents to visit at night.

The strategy was that the data collector visited an address while the Programme Director remained in her car. This was important as, during the 1990 study, one of the team's cars was burnt during one of the visits. In spite of the fact that both the data collector and Programme Director had identification, two calls were made to the Health Board to report two suspicious women, one sitting in a car while the other was visiting houses in the area with small children and asking a lot of questions. The mobility of residents and issues of personal safety can make it extremely difficult to evaluate programmes of this nature.

Results

As a result of intensive searching, 77 of the 232 mother-and-child pairs covered by the 1990 study were located, representing 33 percent of the original sample. One child from the control group was excluded from the survey because she was intellectually disabled and inclusion might have biased the study in favour of the intervention group. There were thus 76 mother-child pairs, all of whom agreed to be interviewed for the follow-up study – a response rate of 100 percent. They were evenly divided between the intervention and the control groups. Table 4.1 shows how mothers included in the study were located.

TABLE 4.1: HOW RESPONDENTS WERE LOCATED

	number	percent
still living at same address	**56**	**75.0**
new address provided by family member	**6**	**7.9**
new address found through General Medical Services register	**13**	**17.1**
Totals	76	100.0

TABLE 4.2: SOCIODEMOGRAPHIC PROFILE OF RESPONDENTS, 1997

Variable	Category	Intervention group		Control group	
		N = 38	percent	N = 38	percent
sex of child	male	15	39.5	18	47.4
	female	23	60.5	20	52.6
mother's age	age range	24 to 39 years		25 to 36 years	
	average age	30.9		30.8	
mother's	employed	20	52.6	18	47.4
employment	unemployed	18	47.4	20	52.6
housing	private	20	52.6	18	47.4
	local authority	18	47.4	20	52.6
mother's marital	unmarried	14	36.8	10	26.3
status	married	22	57.9	23	60.5
	separated	2	5.3	5	13.2

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Demography

Table 4.2 shows that the intervention and control groups were very similar in terms of basic demographic characteristics. The age range for mothers in the intervention group was 25 to 39, which was slightly wider than the mothers in the control group, whose age range was 25 to 36. The average age for mothers in the intervention group was 30.9, whereas it was 30.8 for mothers in the control group. There were slightly more girls than boys among the children in both the groups and their age ranged from seven to nine years, with the majority (85.5 percent) eight years of age.

Half of both groups lived in privately owned accommodations. The majority of mothers in both groups were married. More mothers in the intervention group had a partner – 92 percent, compared with 76 percent in the control group. Three-quarters (74.3 percent) of the partners in the intervention group and two-thirds (65.5 percent) of the partners in the control group were employed outside the home. Based on their current or last occupation, almost one-fifth of the partners in both groups were in higher social classes, two-thirds of the partners in both groups were in the lower social classes, and the occupation of the remaining partners was unknown.

The majority of mothers in both groups had a telephone, central heating and their own garden. Approximately half had a car.

When we compared the socio-demographic profile of the 76 respondents who were traced with the profile of the 156 mothers from the 1990 study who were not traced, we found no significant differences in maternal age, marital status, maternal employment, paternal employment, car ownership or telephone ownership. Therefore the assumption was made that the sub-sample of 76 respondents was representative of the original 232 mother-child pairs.

Immunisations

Mothers were asked whether their child had been given their MMR (measles, mumps and rubella) vaccination and a school booster for earlier vaccinations. There was no significant difference between the groups with regard to immunisation coverage: the entire intervention group had received a booster, compared to 94 percent of the control group. All those in the control group had received their MMR immunisation, whereas the figure for the intervention group was 94.7 percent. The mothers of the two children who had not received the MMR immunisation said they had planned to have their children immunised but were advised not to by their family doctor.

Dental check-ups

Mothers were asked whether their child had received a dental check-up. More children in the intervention group (89.5 percent) than the control group (76.3 percent) had received dental check-ups.

All those who had not received a dental check-up said that the school had not organised them to date.

Accidents

Of the 76 children in the study, 27 had had an accident that required a visit to hospital. Of these, 10 (26.3 percent) were from the intervention group and 17 (44.7 percent) were from the control group. Analysis showed that the risk for having an accident requiring a visit to hospital was lower in the intervention group. The majority of children in both groups had had only one accident.

The majority of accidents in the intervention group (76.9 percent) and in the control group (91.3 percent) had occurred when the child was playing. Two children in the control group drank poison or took medication not intended for them, two children in the intervention group were injured during a sporting activity, and one was hit by an object while playing or fighting with other children. The majority of accidents resulted in a laceration (21); other consequences included a broken limb (11 children) and teeth knocked out (two children).

Three children from the intervention group were admitted to hospital as a result of accidents, compared with two in the control group. There was no significant difference between the average number of days spent in hospital due to accidents between the children in the two groups.

Illnesses

Mothers were asked if their child had ever been admitted to hospital for reasons other than accidents. A higher number of children in the intervention group (17/44.7 percent) were admitted to hospital because of illness than in the control group (8/21 percent). This difference is significant at $p = 0.028$. These admissions were for illnesses not addressed in the CMP. As found in the 1990 study, there was also a difference between the groups in the number of days spent in hospital. The 17 children in the intervention group spent a total of 93 days in hospital, compared to 17 days for the 8 children in the control group.

Reading and the library

Mothers were asked whether they had time to read to their child. Fourteen mothers in the intervention group (36.8 percent) read to their child, compared with 12 mothers (31.6 percent) in the control group. Of the mothers who did not read to their child, 87.5 percent in the intervention group and 73 percent in the control group replied that their child read by him/herself. More children in the intervention group (92.1 percent) compared to the control group (81.6 percent) were either read to by their mothers or read by themselves.

Over three-quarters (78.6 percent) of the mothers in the intervention group who read to their child did so on a daily basis, compared to half of the mothers (50

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percent) in the control group. All of the children in the intervention group were said to enjoy reading, compared to 94.7 percent in the control group.

The majority of mothers in both groups never went to the library for themselves although many did take their children to public libraries. Twelve mothers (31.6 percent) in the intervention group said that they went to the library for themselves, while only six mothers (15.8 percent) in the control group did so. Six of the intervention group mothers and just two of the mothers in the control group said that their library visits were weekly.

Mothers were asked how often their child visited the library. From Table 4.3 it can be seen that more children in the intervention group visited the library regularly than children in the control group and that the intervention group children were much more likely to make weekly visits to the library than their counterparts in the control group. The difference in weekly visits is significant at $p = 0.009$. Three children in the intervention group (7.9 percent) never visited the library, compared with 9 children (23.7 percent) in the control group.

Television and bedtime

Mothers were asked what type of programmes they would not allow their children to watch on television. The majority in both groups stated that they

TABLE 4.3: HOW OFTEN CHILDREN VISITED THE LIBRARY

Frequency of children's library visits	Intervention group N = 38	Intervention group percent	Control group N = 38	Control group percent
weekly*	30	78.9	19	50.0
every two weeks	1	2.6	2	5.3
monthly	4	10.5	8	21.1
never	3	7.9	9	23.7
Totals	38	100.0	38	100.0

*Significant at $p = 0.009$.

TABLE 4.4: HOW OFTEN MOTHERS CHECKED THEIR CHILD'S HOMEWORK

Frequency of checking homework	Intervention group N = 38	Intervention group percent	Control group N = 38	Control group percent
every night*	38	100	31	81.5
less than every night	0	0	7	18.4
Totals	38	100	38	100

*Significant at $p = 0.009$.

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would not allow their child to watch adult programmes, violent programmes or sexually explicit programmes. More mothers in the intervention group (97.4 percent) than the control group (86.8 percent) stopped their child watching television by 9 p.m. on weekdays. More mothers in the intervention group (92.1 percent) compared with the controls (86.8 percent) said that their child was in bed by 9 p.m. on weekdays. More children in the intervention group (84.2 percent) were in bed by 10 p.m. on weekends, compared to the control group (71.1 percent).

School and homework

Similar proportions of children in both groups had started school at four years of age: 60 percent in the intervention group and 52 percent in the control group. Almost all children in both groups were said to enjoy school and to mix well. Only nine children in the intervention group (23.7 percent) had been bullied in school, compared to 14 in the control group (36.8 percent). Table 4.4 summarises the mothers' responses to the question about whether they checked their children's homework and, if so, how often. The difference was highly significant at $p = 0.006$, with all the mothers in the intervention group saying that they checked their children's homework every night. In the control group, 31 (81.5 percent) mothers checked their child's homework every night.

Attitudes towards childcare and discipline

Table 4.5 summarises the responses given by mothers to five statements concerned with childcare and discipline. For three of the statements the responses of the mothers in the two groups were the same: they all agreed that it is important to know who their children's friends are, equal proportions (84 percent) believed that horror videos affected children, and equal proportions (95 percent) agreed that parents should become involved in their children's schooling. There was a significant difference ($p = 0.011$) between the groups on whether parents enjoy participating in their child's games: all the mothers in the intervention group agreed with the statement, while six of the mothers in the control group did not agree with the statement.

There was also a significant difference concerning discipline ($p = 0.018$). Half of the mothers in the intervention group did not agree that children should be smacked for persistent bad behaviour, while less than a quarter (nine mothers, or 23.6 percent) of the mothers in the control group disagreed with the statement.

Nutrition

A 24-hour dietary recall was done for both mothers and children. Although there were no significant differences in diets between the intervention and the control groups, the nutritional intake of children in the

TABLE 4.5: ATTITUDES OF MOTHERS TO CHILDCARE AND DISCIPLINE

Statement	Intervention group N = 38				Control group N = 38			
	agree		disagree		agree		disagree	
	no.	%	no.	%	no.	%	no.	%
Children should be smacked for persistent bad behaviour*	19	50.0	19	50.0	29	76.3	9	23.6
Horror videos do not have any effect on children	6	15.8	32	84.2	6	15,8	32	84.2
It is important for parents to know who their children's friends are	38	100	–	–	38	100	–	–
Parents should not become involved in their child's schooling	2	5.3	36	94.7	2	5.3	36	94.7
Parents enjoy participating in their child's games**	38	100	–	–	32	84.2	6	15.8

*Significant at p = 0.018.

**Significant at p = 0.011.

intervention group was consistently better (between 11 percent and 63 percent better) than the control group for particular food groups. For example, over half of the children in the intervention group received the appropriate intake of vegetables and fruit, compared to just over one-third of children in the control group.

So far as the mothers' diet was concerned, apart from having an appropriate energy and protein intake, the majority in both groups did not have the appropriate intake of any other food group. However, a greater proportion of mothers from the intervention group, as compared to the control group, received the appropriate amounts of whole food, vegetables, fruit and milk.

Mothers' self-esteem

Mothers' self-esteem was assessed in two ways. They were first asked about the four indicators that had been used in the 1990 study – how often they felt tired, had headaches, felt miserable or did not want to go out. Although there were no significant differences between the two groups, the mothers in the intervention group had a lower risk of suffering any of the four symptoms than the mothers in the control group.

Second, the mothers were asked to respond to nine statements in the Rosenberg Self-esteem Scale (Rosenberg, 1965). The intervention group mothers were found to be significantly more likely to give a response indicating

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TABLE 4.6: RESPONSES TO THE ROSENBERG SELF-ESTEEM SCALE

Statement	Intervention group N = 38		Control group N = 38		
	number	percent	number	percent	
	agree		agree		p Value
I am a person of worth	37	97.4	32	84.2	0.054
I have good qualities	38	100	36	98.7	0.49
I do things as well as others	36	94.7	35	92.1	1.00
I am satisfied with myself	32	84.2	28	73.7	0.483
I have a positive attitude towards myself	33	86.8	26	68.4	0.056
	disagree		disagree		
I do not have much to be proud of	37	97.4	29	76.3	0.014
I want more respect	20	52.6	13	34.2	0.129
I feel useless at times	24	63.2	21	55.3	0.478
I feel no good at all	37	97.4	33	86.8	0.199

higher self-esteem on two of the statements (see Table 4.6).

Taken overall, the responses to all these questions show a definite tendency for the intervention group mothers to have higher levels of self-esteem than the control group mothers.

Activities outside the home

Mothers were asked whether or not they were involved in any clubs or other activities outside the home. More of the intervention group (26.3 percent) were involved in activities outside the home, compared with the control group (13.2 percent). The main types of activities were children's clubs, committees and physical fitness.

The future

Mothers were asked if they felt hopeful about the future. The majority of mothers in both groups felt hopeful about the future and also felt they could ask for help from family or friends when they needed it.

Attitude towards being a mother

Mothers were asked how they felt about being a mother now that their child was eight years old. Three-quarters of the mothers in the intervention group (73.7 percent) gave replies such as *The best thing I've ever done* and *I would not be without them.* Only half of the mothers in the control group (50 percent) expressed similar attitudes. This difference is significant at $p = 0.018$.

Subsequent children

Since the 1990 study, the mothers in this sample had given birth to 91 children, 45 to 28 mothers (73.7 percent) in the intervention group and 46 to 31 mothers (81.6 percent) in the control group. The majority in both groups had had only one additional child.

The mothers were asked if they had learned anything during their oldest child's first year that was useful in raising their other children. Twenty-three (82.1 percent) of the mothers from the intervention group felt that they had, compared to 17 (56.7 percent) in the control group. This difference is significant at $p = 0.036$. When asked what they had learned, the intervention group mothers were significantly more likely than the control group ($p = 0.03$) to highlight items such as how to relate to the child, with responses such as, *how to play with the child* and *how to respond to the child's behaviour.*

More of the mothers in the intervention group who indicated they had learned something in their eldest child's first year that was useful in raising their other children said that they had learned to cope when their child was ill. Forty-three percent of the mothers in the intervention group said they could cope, while the figure for the control group was only 29.4 percent

The majority of subsequent children in both groups were of the age when they should have completed their primary and MMR immunisations. It was found that significantly more subsequent children in the intervention group had completed their Haemophilus influenzae b immunisation (HIB) ($p = 0.08$) and polio immunisation course ($p = 0.027$) compared with the control group.

More children in the intervention group (24.4 percent) were breastfed, compared with the children in the control group (13.0 percent). Although the difference was not significant, mothers in the intervention group were nearly twice as likely to breastfeed their children.

Safety means parents, and older children, THINKING SAFE.

- Every year many Irish children die as a result of accidents.
- Many many more are admitted to hospital with severe injuries.
- Some of these will be affected for life.

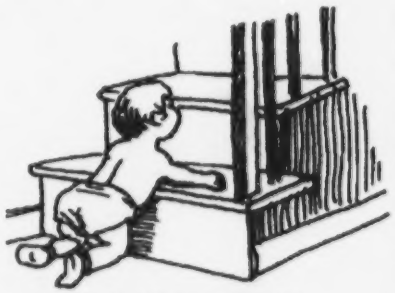
This Cartoon is about ***AWARENESS***:

Parents need to be aware that most child accidents occur in the home.

These pictures show some of the most common risks

Children playing with plastic bags may suffocate.

A child can easily mistake tablets for sweets



A child can easily have a nasty fall

Electric leads and cables are a common cause of injury to small children.

All children need constant watching when they are in or near water.

Parents need to THINK and BE AWARE of each of these FIVE main AREAS of DANGER:

BREATHING..SWALLOWING..MOVING..TOUCHING..WATER

THINK SAFE! ***EVERY CHILD, EVERY TIME, EVERY PLACE!***

Discussion

The randomised controlled trial is regarded as the best way to evaluate any health intervention, and conclusions about long-term benefits of interventions can be strengthened if a follow-up evaluation is carried out on the randomised groups. This was the main motivation for undertaking the seven-year follow-up study.

The high rate of mobility among the original study participants presented difficulties, but this is typical of young disadvantaged mothers in Ireland, and possibly throughout the world. Despite this, in our favour were the facts that equal numbers of mothers from the 1990 intervention and control groups were located, that all agreed to be interviewed and that there was no significant difference in the socio-demographic profiles of the two groups.

The 1997 study

Accidents

More children from the control group had an accident requiring a visit to hospital. The greater number of accidents among children in the control group suggests that the intervention mothers may have been more observant of their children. Having an awareness of their children and how they develop is an important part of the Programme strategy. More specifically, parents in the Programme are encouraged to 'think safe' wherever their child may be and when in a new situation. They are encouraged to think safe by remembering and focusing on the five principal sources of accidental danger: moving, touching, breathing, water and swallowing. This message is reinforced on a number of Programme visits. It appears from the results that once parents have grasped the concept, they are strongly motivated to remain safety conscious. While accidents at play are a normal part of growing up and can be expected, the two incidents of accidental poisoning both occurred in the control group and were preventable.

Hospitalisation

Intervention mothers made more use of hospital than the control group, which could be interpreted as being more proactive in their use of medical facilities. Accordingly, it could be argued that the intervention mothers were better able to attend to their children's health needs because they were more comfortable approaching and taking advantage of the health system. Also, as Programme mothers, they would have been helped to understand that they must take some responsibility for considering how ill their child was and whether it was necessary to bring the child to hospital or deal with the illness themselves. This could have some bearing on the behaviour of the intervention mothers in the follow-up study with regard to their children's illnesses and visits to hospital.

This could also help explain the surprising finding that, despite randomisation, children in the intervention group were

cartoon: Artwork and layout: Gordon Harper, © 2000 Community Mothers Programme

admitted to hospital more than those in the control group, which was similar to the findings in the 1990 study. These children were admitted for various illnesses that were beyond the scope of the Community Mothers Programme and could not be expected to be influenced by it (examples are appendicitis, asthma).

Parenting and child development

An important finding of the follow-up study was the persistence of superior parenting skills and cognitive, language and educational development among the intervention families. In the 1990 study, intervention mothers were more likely to read to their child daily, to play cognitive games and to read nursery rhymes. Seven years later these parents stated that they were just as involved with their children.

Not only were the intervention children more likely to be read to by their mothers but they were also more likely to be reading themselves. The mothers in the intervention group who read to their child were also more likely to read to them daily. As Programme mothers, the intervention mothers would have been encouraged to find a quiet time every day in order to read to the child or to tell stories, starting from when the child was six months old. They would have been given information on choosing suitable books and encouraged to borrow books from the library. And they would have been encouraged to see themselves as the child's first and most important teacher, teaching social, language, cognitive and educational skills, all of which are important for the development of the child. Equally, they would have been encouraged to recognise the importance of participating in the learning activities of their child as often as possible. This may have had some influence on the finding that most of the children in the intervention group enjoyed reading.

Programme mothers are encouraged to see the library as an important resource and are encouraged to enrol their children and themselves. It was therefore disappointing to find that only one-third of the intervention mothers went to the library, but this was still nearly twice as many mothers as in the control group. Also, intervention mothers were more likely to go on a weekly basis. It was positive to find that children in the intervention group were significantly more likely to be enrolled at the library than the control group and also that they were more likely to visit on a weekly basis.

It was also reassuring to find that significantly more intervention mothers enjoyed participating in their children's games compared with the controls.

Television

Both groups of mothers exercised some control over the television programmes that their children watched, with adult, violent and sexually explicit programmes

being banned. It is interesting to note that more intervention mothers stopped their children watching television at an earlier time during weekdays than the control group. As Programme mothers, they would have been encouraged to use television in a creative way and would have been given an awareness of the power of television and its usefulness for educating children. It would appear from these results that the goal of developing an awareness in Programme mothers that they needed to develop some control over this medium if they were to use it creatively had been achieved.

School

As Programme mothers, the intervention group would have been encouraged to foster their children's development by praising and guiding the child. Everything was done to raise the mother's awareness of the tremendous importance of her work, and she was helped to feel successful and competent as a parent and to see her role as very important. Seven years after the 1990 study, the children in both groups were enjoying school and mixing well, but the study showed that the intervention children were less likely to have been bullied at school and the intervention mothers were significantly more likely to check their child's homework every night.

Discipline and children's behaviour

The study found a significant difference between the two groups of mothers with regard to attitudes to smacking. Mothers in the intervention group were more likely to oppose smacking than those in the control group. Having a supportive programme, combined with information on alternatives to smacking, appears to have played a role.

An important aspect of the CMP is to give parents information on positive approaches to parenting and to develop their skills. The Programme also increases the parents' ability to deal with children's behaviour and gives them the opportunity to discuss alternatives in the light of their own experience and prior beliefs.

Behavioural guidance is achieved by empathic reasoning rather than by displays of parent-power. In addition to a positive attitude towards discipline, this approach could, for intervention mothers, reduce loss of control or cases of over-chastisement, which could lead to actual physical abuse. The findings of three cases of child abuse among the control group in the 1990 study and none in the intervention group is important. It appears that the intervention mothers in the follow-up study had, from their experience in the Programme, developed good strategies that could also help them and their children deal with conflict in the future.

Nutrition

The follow-up study demonstrates more appropriate dietary intake by both children

and mothers in the intervention group. As Programme mothers, the intervention group would have been encouraged to adopt a healthy approach to eating and a common-sense, balanced approach to nutrition. They would have been encouraged to see diet as crucial to health and mental well-being and they would have been encouraged to breastfeed their child. They would have been helped to understand the concept of 'junk' foods and better quality foods, and they would have been encouraged to think of healthy alternatives to junk foods that are more enjoyable for their child.

Programme mothers would also have an awareness of poor nutrition and the problems it can lead to, such as obesity and/or tooth decay. Most important, the intervention mothers would have been encouraged in the child's first year to find solutions to their own and their child's nutrition problems rather than being told what was a good diet. The results of the follow-up study show that the principles of good nutrition appear to have been maintained to some degree by the intervention mothers, even though there was no significant difference between the nutrition of the intervention and control groups. For example, the nutritional intake of intervention children was between 11 percent and 63 percent better than control children for individual food groups such as milk, fruit and vegetable intake and whole foods. Also, a greater proportion of intervention group mothers received the appropriate amount of whole foods, vegetables, fruit and milk.

The work in this area continues. The Programme has been extended to the first two years of the child's life and greater emphasis has been placed on family nutrition. In this way we hope to achieve a persistent improvement in maternal and child nutrition.

Self-esteem

One of the aims of the CMP is to develop the skills of parents of young children and build their self-esteem. This is achieved by drawing on the potential of the mother rather than giving advice and direction. The parents are encouraged to undertake agreed tasks and are shown, through illustrated sheets, the alternatives available in coping with various childrearing problems.

Self-esteem is important for psychological well-being and the roots of it lie in experiences where parents feel competent. The CMP appears to have had a lasting beneficial influence on maternal self-esteem. The information and support provided by the CMP and the positive feedback received from the Community Mother could have played a role in getting the intervention mothers off to a good start and giving them a buffer against feelings of failure. This could have an impact on building and maintaining their self-esteem.

The 1990 study showed that significantly more intervention mothers had good self-esteem and, while the differences between the control and the intervention mothers in the 1997 study were not statistically significant, there was a definite tendency for the intervention mothers to have higher levels of self-esteem than the control group.

Both the control and intervention mothers felt connected and supported and were hopeful about the future. They also felt that they could ask for help from family or friends when they needed it. The fact that the Programme is operating in working class communities could be a reason for this, with some adult children still living close to, and being supported by, parents and relatives.

Attitudes towards motherhood

The Programme also appears to have had a lasting beneficial influence on attitudes towards motherhood, with significantly more intervention group mothers continuing to report positive feelings. Their good self-esteem may be a factor in this. They have also had good experiences, feel good about what they are doing and are confident in their ability to function effectively in their role. They can acknowledge their skills and talents. An illustrated sheet aimed at fostering self-esteem and an awareness of the importance of the mother's role is given to Programme mothers. In addition, the attention given to the mother in the Programme is itself evidence of the importance of her role and this is reinforced during the Programme visits.

Subsequent children

Subsequent children have benefited from the Programme. The documentation of superior immunisation records in subsequent children in the intervention group is particularly encouraging. Programme mothers are given a friendly pictorial reminder about immunisation because constant reminders are seen as counterproductive. The principal arguments for and against having one's children immunised are discussed with the parents and the type of immunisation available for infants and children is shared with them. They are encouraged to discuss any anxieties they may have with their family doctor.

When the CMP began, it was offered when the mother had left hospital after the birth of the child, so breastfeeding rates were unlikely to be affected. It was encouraging to find in the follow-up study that intervention mothers were more likely to breastfeed subsequent children. The CMP has been altered since the time of the 1990 study and expectant mothers are now visited whenever possible. Breastfeeding support groups have been established and breastfeeding mothers are now offered weekly breastfeeding support visits for the first eight weeks following the birth of the child.

Another positive finding was that significantly more intervention mothers reported that they had learned things in their child's first year that helped them with subsequent children, for example, how to relate to their child. They acknowledge and are making use of the skills developed when they had their first child.

Conclusions

It is interesting to note that Community Mothers in a previous study stated that they could have an influence on the community in their role as a Community Mother (Molloy, 1992). They felt that they were in a position to give relevant information on health issues and early education. They said that they felt they could influence childrearing practices, which would have implications for the community in the future, and that by helping to build parents' self-esteem, the parents would then be in a better position to take control of their lives. The results of this study appear to confirm this. Community Mothers working in partnership with Family Development Nurses have been very effective.

Overall, almost all the variables measured favoured the intervention group despite the fact that they were not all statistically significant. The aim of the CMP is the development of the child both physically and mentally through the empowerment of the mother and by raising the awareness in parents that bringing up children is probably the most important task that most people will undertake in their lifetime. Getting them to take on board the link between stimulation and guidance and the child's developmental progress is shown to be vitally important.

In conclusion, this study documents the fact that the changes in childrearing practices found by the 1990 study have been sustained seven years later.

The future

The results of the follow-up study have shown that the benefits of the CMP have been sustained for both mothers and children. There has been no 'wash out'. Of equal importance is the fact that it has shown that it is possible to develop, implement and maintain, even within the confines of a health bureaucracy, a programme that contains within it processes directed at human development, contributing to both health and well-being.

A new Irish health strategy is being developed at present; it would be positive to see the Programme recognised and its benefits for individual families and communities valued by policy makers. The Programme needs further support in order to grow from its present base to a broader national one. The Programme could be further developed both nationally and internationally. The challenge would be our ability to maintain the essence of the Programme while at the same time transferring the concept.

The success of the Programme in recent years has led to the development of peer-led interventions in other Health Boards in Ireland, as well as in the United Kingdom, the Netherlands, Sweden, Australia and the USA. These programmes have not, to date, been evaluated by randomised controlled trial and it is thus difficult to compare them with the CMP.

The CMP is still going strong; it has received international acclaim and has undergone external evaluation (Mental Programme delivered by non-professional volunteer mothers in partnership with 'de-roled' professionals, it provides benefits and advantages to families and future generations.

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photo: Programme mother and child, photo courtesy Community Mothers Programme

Appendix one

Seven-year follow-up study questionaire

Code no. .....
Case no. .....
Date of interview .....
Community Care Area .....

1. Name of Child .....
2. Sex of Child
   Boy ⌟ Girl ⌟
3. Child's Date of Birth
   ⌟⌟⌟⌟⌟⌟

4. Has your child been given the following vaccinations?
   MMR Yes ⌟ No ⌟
   School Boosters Yes ⌟ No ⌟
5. Does your child have dental check-ups?
   Yes ⌟ No ⌟
   if no, why? .....
6. Has your child had any accidents that required a visit to hospital?
   Yes ⌟ No ⌟

6a. How many accidents required a visit to the hospital?
.....

Type of accident .....
Type of injuries .....
Number of days in hospital ..... Age .....

Type of accident .....
Type of injuries .....
Number of days in hospital ..... Age .....

Type of accident .....
Type of injuries .....
Number of days in hospital..... Age .....

Type of accident .....
Type of injuries .....
Number of days in hospital ..... Age .....

7. **Has your child ever been admitted to hospital for other reasons?**
   Yes ⌟ No ⌟
7a. **How many times was your child in hospital for other reasons?**
   .....

   Reason for hospitalisation .....
   Number of days in hospital ..... Age .....

   Reason for hospitalisation .....
   Number of days in hospital ..... Age .....

   Reason for hospitalisation .....
   Number of days in hospital ..... Age .....

   Reason for hospitalisation .....
   Number of days in hospital ..... Age .....

8. **Do you have time to read to your child?**
   Yes ⌟ No ⌟
   if yes ....question 9
9. **How often do you read to him/her?**
   .....
10. **Does your child enjoy reading or looking at books?**
   Yes ⌟ No ⌟
11. **How often would you go to the library?**
   .....
12. **How often would your child go to the library (School or Public)?**
   .....
13. **What type of programmes, if any, do you not allow your child to watch on television?**
   .....
14. **During the week nights what time do you stop your child watching television?**
   .....

15. Approximately what time does your child go to bed, during week nights and at the weekend?
    Week nights .....
    Weekend nights .....
16. Does he/she enjoy school?
    Yes ☐ No ☐
    if no, why? .....
17. Has your child ever been bullied at school?
    Yes ☐ No ☐
18. Do you feel your child mixes well with other children?
    Yes ☐ No ☐
19. How often would you check that your child has done their homework?
    Always ☐ Often ☐ Sometimes ☐ Never ☐
20. Do you agree or disagree with the following statements?

	Agree	Disagree
Children should be smacked for persistent bad behaviour	☐	☐
Horror videos do not have any affect on children	☐	☐
It is important for parents to know who their children's friends are.	☐	☐
Parents should not become involved in their child's schooling	☐	☐
Parents enjoy participating in their child's games	☐	☐

21. What did your child have to eat yesterday?
    (including snacks)
    .....
    .....
    .....
    .....
    .....
22. What did you have to eat yesterday?
    (including snacks)
    .....
    .....
    .....
    .....
    .....

Code No. ❑	Case No. ❑❑❑

23. How often do you feel . . . . .

	Never	Sometimes	Often	Always
Tired	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Miserable	❑	❑	❑	❑
Do not want to go out	❑	❑	❑	❑

24. Do you agree or disagree with the following statements?

	Agree	Disagree
I am a person of worth	❑	❑
I have good qualities	❑	❑
I do things as well as others	❑	❑
I do not have much to be proud of	❑	❑
I am satisfied with myself	❑	❑
I want more respect	❑	❑
I feel useless at times	❑	❑
I feel no good at all	❑	❑
I have a positive attitude toward myself	❑	❑

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25. Are you involved in any clubs or other activities outside the home

Yes ❑ No ❑

if yes.....please specify

.....

.....

26. Are you hopeful about the future?

Yes ❑ No ❑ Don't know ❑

27. Do you feel able to ask for help from your family/friends when you need it?

Yes ❑ No ❑ Don't know ❑

28. Now that your child is eight years old, how do you feel about being a mother?

.....

.....

.....

29. Have you had any other children?

Yes ❑ No ❑

30. How many other children do you have?

.....

31. Did you learn anything during your oldest child's first year that was useful in raising your other child/children?

Yes ☐ No ☐

if yes.....please specifiy

.....

.....

.....

Name of Child.....

Birth Date

.....

Vaccinations	MMR	3 in 1	2 in 1	HIB	Polio
	☐	☐	☐	☐	☐
Completed Course		☐	☐	☐	☐

Breast Feed

Yes ☐ No ☐

Name of Child.....

Birth Date

.....

Vaccinations	MMR	3 in 1	2 in 1	HIB	Polio
	☐	☐	☐	☐	☐
Completed Course		☐	☐	☐	☐

Breast Feed

Yes ☐ No ☐

Name of Child.....

Birth Date

.....

Vaccinations	MMR	3 in 1	2 in 1	HIB	Polio
	☐	☐	☐	☐	☐
Completed Course		☐	☐	☐	☐

Breast Feed

Yes ☐ No ☐

32. **Are you living in ...**

Privately Owned House	⌟
Privately Owned Flat	⌟
Privately Rented House	⌟
Privately Rented Flat	⌟
Corporation Rented House	⌟
Corporation Rented Flat	⌟

33. **Do you have any of the following**

Phone	⌟
Car	⌟
Central Heating	⌟
Own Garden	⌟

34. **Are you employed outside the home?**

Yes ⌟ No ⌟

35. **Present/last occupation**

.....

36. **Do you have a partner?**

Yes ⌟ No ⌟

37. **Is your partner employed?**

Yes ⌟ No ⌟

38. **Present/last occupation**

.....

39. **Mothers Birth Date**

.....

40. **Marital Status**

Unmarried	⌟
Married	⌟
Separated	⌟
Divorced	⌟
Widowed	⌟

Further information

Information about the Foundation, its grantmaking policy, and its work, as well as a list of publications, are available from the Foundation through the contact details given on the back cover.

Titles in the *Following Footsteps* series:

A new door opened: a tracer study of the Teenage Mothers Project, Jamaica
Roli Degazon-Johnson, 2001, Practice & Reflections No. 13

In the web of cultural transition: a tracer study of children in Embu District, Kenya
Ann Njenga & Margaret Kabaru, 2001, Practice & Reflections No. 14

The challenges of change: a tracer study of San Preschool children in Botswana
Willemien le Roux, February 2002, Practice & Reflections No. 15

To handle life's challenges: a tracer study of Servol's Adolescent Development Programme in Trinidad, Jean Griffith, February 2002, Practice & Reflections No. 16

Still going strong: a tracer study of the Community Mothers Programme, Ireland
Brenda Molloy, April 2002, Practice & Reflections No. 17

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Many early childhood programmes use home visiting as a strategy; in the Community Mothers Programme, it is **the** strategy. The Community Mothers are all women from the community who volunteer to visit first-time parents in their homes – once a month for one hour over a twelve-month period.

Can just 12 contact hours over a year make any difference to the child and the mother? Remarkably, this report shows that it can. In 1989, 232 first-time mothers in disadvantaged areas of Dublin were randomly selected to be in either a group receiving the Programme or a control group that did not. A study when their babies were one year old showed favourable outcomes for the Programme families, when compared with the control families, in areas such as maternal self-esteem, maternal and child nutrition, developmental stimulation, maternal morale and well-being, and immunisation.

Seven years later, when the children were aged eight, a follow-up study traced one-third of the families from the 1990 study. A major finding was the persistence of superior parenting skills among the Programme families. Children whose mothers had been in the Programme were more likely to read books, to visit the library regularly, to have better nutritional intake. Mothers had higher levels of self-esteem. They were also more likely to oppose smacking, to have developed strategies to help them and their children deal with conflict, to enjoy participating in their children's games, to have better nutritional intake, and to express positive feelings about motherhood.

This is a programme that operates at the community level, that begins at or even before birth, that empowers the women who implement the programme as well as the families that are visited, and that is helping some two thousand children a year to reach towards their full potential.

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